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Review and Audit of the 1999/2000 Nursing Enhancement Fund

Final Report Submitted to the Implementation Monitoring Sub-Committee of the Joint Provincial Nursing Committee

April, 2001

HayGroup

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Executive Summary

Background, Objectives and Methodology

Nursing Task Force

The Nursing Task Force was established in response to concerns regarding the future supply and retention of RNs and RPNs in the nursing profession in Ontario. Two key recommendations of the Nursing Task Force were to:

1. Immediately enhance health care delivery through nursing services by stabilizing the nursing workforce and improving retention of existing nursing.
2. Provide ongoing structured opportunities for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and operational level.

Nursing Enhancement Fund

In response to recommendation 1, the Minister of Health and Long-Term Care announced on March 19, 1999 that the government would provide $375 million to create 12,000 new nursing positions by March 31, 2001. Part of this commitment is the Nursing Enhancement Fund (NEF) earmarked for the creation of new, permanent full-time and part-time positions. The Government's commitment to nursing in 1999/2000 included investing:

- $130 million new base funding annually to hospitals to create 3,300 new nursing positions in 1999/2000;
- $24 million in new funding annually to in-home services of which a minimum of 60 percent was to be spent on nursing services to create 500 new nursing positions in 1999/2000; and,
- $20 million in new funding annually to long-term care (LTC) facilities to create 650 new nursing positions in 1999/2000.

The remainder of the investment is allocated through new and existing programs (i.e. priority programs, Emergency room funding, etc.) as well as for basic and continuing education for nurses, nursing research, hiring nurse practitioners, and recruitment and retention strategies.

The NEF was made available to hospitals, LTC facilities and Community Care Access Centres (CCACs) in Ontario, provided that each organization develop and implement a

nursing plan consistent with the government's nursing strategy.

Review Objectives

There is a need to ensure the proper implementation of the Nursing Task Force recommendations. The Nursing Task Force gave the Joint Provincial Nursing Committee (JPNC) the responsibility for monitoring the NTF recommendations. As part of the monitoring process, the Ministry of Health and Long-Term Care commissioned and funded this review and audit of the use of the 99/00 Nursing Enhancement Funds provided to health care organizations and the Implementation Monitoring Subcommittee (IMS) of the JPNC acted as the steering committee. The purpose of this review and audit is to ensure accountability for the appropriate expenditure of the funds intended to improve the availability of and public access to nursing services through increasing permanent employment for nurses. The project has focused on identifying how the Nursing Enhancement Fund was used versus the 1999/000 approved nursing plan and instructions from the MOHLTC, and identifying issues that organizations faced in implementing their 1999/00 Nursing Plans (hospitals) or Nursing Profiles (LTC facilities and CCACs).

Organizations Included in Review

The IMS selected a sample of 30 organizations (16 hospitals, 7 Long Term Care Facilities and 7 Community Care Access Centres) to be included in the review. Twelve of the 30 organizations received an on-site visit as part of the review and audit.

Findings: Hospitals

Payroll Survey Findings

A survey of the sample hospitals was conducted to collect payroll data as a basis for determining the numbers of net new nursing positions for Registered Nurses (RNs) and Registered Practical Nurses (RPNs) by employment status (full-time, part-time, or casual) created as a result of the 1999/2000 Nursing Enhancement Fund.

Overall, the survey indicates that the total number of paid hours for nursing increased by 4.84% from 1998/1999 to 1999/2000. This increase represents approximately 582 full-time equivalent (FTE) positions in the sample hospitals. Results from this target sample of hospitals may not represent all hospitals.

MIS Trial Balance Data Findings

A parallel analysis of MIS trial balance data shows that acute care inpatient nursing hours per day have increased 5.3%. For long-term beds (including rehabilitation and complex continuing care beds), there was a slight overall decrease in nursing hours per patient day. And, for Emergency Services, there was a 9.2% increase in nursing hours.

Quality of Reporting

Many hospitals reported that there were a number of provincial initiatives in progress at the same time, which made it difficult to report NEF-specific allocations. Without specific tracking mechanisms, it is difficult to track positions created using the NEF. Some hospitals expressed a fundamental concern with the use of targeted funding for specific services in a globally funded organization. There was a perception that the Ministry of Health and Long-Term Care's accountability requirements result in micro-management in the health care system and interfere with the management of individual hospitals.

It is recommended that:

(1) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should clearly define the accountability and reporting requirements associated with targeted programs such as the Nursing Enhancement Fund in advance of distributing the funds.

It was suggested that the Ministry might modify its MIS reporting requirements to allow for the creation of a reporting structure within MIS that could be used to record NEF revenues, staffing and related allocations, allowing the Ministry to track changes in all staffing categories (RN, RPN, etc.).

It is recommended that:

(2) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care modify the Ontario Hospital Reporting System to provide for sub-accounts within each functional centre for use in tracking different types of nursing hours.

(3) Ontario hospitals should modify their tracking and reporting systems to provide sub-accounts within each functional centre to facilitate tracking and reporting of different types of nursing hours.

There appears to be a lack of specific reporting at the senior management level on levels of nursing staff within hospitals. While there are reports to track variances of budgeted costs on the nursing units, reporting of nursing hours in general, and NEF-funded positions and vacancies in particular, is not widespread.

It is recommended that:

(4) The Joint Provincial Nursing Committee recommend that hospital Chief Nursing Officers and senior managers ensure a mechanism is established for monitoring variance from the planned use of Nursing Enhancement Funds.

Implementation Issues

Within the hospital sector, there was some initial confusion about intent of the new funding. There was a general sense that the funds should be able to be spent on recruitment, training, support workers, clerical staff, equipment, or any other item that improves the quality of work life for nurses.

It is recommended that:

(5) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should develop clear guidelines for the use of targeted funds at the time that new funding is announced.

The timing of receipt of funds was problematic for many organizations. Receiving the funds in September made it difficult and in some cases impossible to spend all the funds before the end of the fiscal year. As a result, some hospitals used these monies for one-time nursing-related expenditures, such as educational programs and professional development.

It is recommended that:

(6) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should ensure that annualized funds are received by hospitals at the beginning of the fiscal year in which they are required to be allocated.

A number of hospitals commented on experiencing higher than expected costs to recruit nursing staff to fill new positions. Many organizations, including hospitals and CCACs reported making attempts at regional human resources

planning and conducting joint recruiting efforts such as job fairs in an attempt to reduce recruiting costs and avoid direct competition for new staff.

It is recommended that:

(7) The Joint Provincial Nursing Committee should encourage and facilitate regional and collaborative nursing human resources planning and recruiting efforts.

Some hospitals expressed concern with the limited amount of involvement of Chief Nursing Officers in the province in helping the Ministry to establish priorities for funding. There was a lack of clear direction from the Ministry regarding reporting requirements when the funding was first announced.

It is recommended that:

(8) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should consult stakeholders and end-users when developing new reporting systems in all sectors (such as Chief Nursing Officers and Finance Director).

Achieving NEF Commitments

As part of the 1999/2000 Operating Plan, hospitals were required to prepare a Nursing Plan that described how the NEF would be spent in their organization. Based on the 1999/2000 Nursing Plan, the hospitals included in the review and audit reported a planned increase in nursing hours of 5.4%.

In order to determine whether hospitals' plans were achieved, the commitments contained in the 1999/2000 Nursing Plan was compared with the 1999/2000 actual staffing presented in the 2000/2001 Nursing Plan. Nine of the 15 hospitals for which data are available reported that in1999/2000 actual paid hours were equal to or greater than their commitments in the 1999/2000 Nursing Plan.

Findings: Long-Term Care Facilities

Long-Term Care Data Findings

In the six locations included in the sample, total nursing hours increased by 27,573 hours, or approximately 6.9%. The increased number of nursing hours represents a net increase of approximately 14 full-time equivalent nursing positions.

Quality of Reporting

The tracking and reporting of the NEF in LTC facilities is fairly straightforward due to the relatively small amount of

funding allocated to each facility and the relatively small number of RN or RPN nursing staff employed. It was reported that it would be much simpler to incorporate the NEF into existing reports. LTC facilities have relatively few administrative support resources; it is difficult to absorb additional reporting requirements.

It is recommended that:

(9) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care, should integrate NEF reporting with other reporting requirements in the LTC sector to ease the burden on the limited administrative staff.

Implementation Issues

The most significant implementation issues reported by the two sites are recruitment and retention of nursing staff. Facilities use a variety of recruitment strategies, but still find it difficult to compete for available nurses with other health providers. Recruitment and retention problems have been exacerbated because, for LTC facilities, the Ministry has treated the NEF as one-time annual funding, requiring an annual application process. Although the funding is described as "ongoing", LTC facilities have found it difficult to recruit new staff, as they are unable to make a commitment of more than one year at a time. The inability to hire permanent staff into these positions affects the quality of care provided.

It is recommended that:

(10) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should include the Nursing Enhancement Fund as a separate and permanent line item in the nursing and personal care funding envelope of long-term care facilities.

Participation in Planning and Decision-Making

Both sites visited are part of larger corporate entities. In both cases, for the most part, planning and decision-making regarding NEF took place at "head office". Nevertheless, both provided opportunities for input from facility nurses at both management and front-line levels. Input from nurses at regular team meetings and in general meetings with the Director of Nursing was taken into consideration in developing plans

Findings: Community Care Access Centres

CCAC Data Findings

Five CCACs reported spending an amount equal to or greater than the enhanced level of nursing services planned for in the Baseline Data and Quarterly Report. Some CCACs did not allocate the NEF as planned due to reductions in client volumes and/or nursing agencies' inability to meet service demand. (Need to explain in sentence or two why an inability to meet service requirements preclude spending the NEF to add new nursing positions)

Quality of Reporting

It was noted by a number of participants during the site visits that the reporting requirements of the NEF are not consistent with how CCACs operate or other systems that are currently in place. The Baseline Data and Quarterly Reports are the only way to track the use of the NEF. (Need sentence or two about why the reporting requirements are not consistent with the way CCACs operate)

It is recommended that:

(11) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should integrate NEF reporting with other CCAC reporting requirements.

Current reporting methods may not meet the Ministry's objectives for the NEF. For some organizations, the Baseline Data and Quarterly Reports were only a mathematical exercise to satisfy the requirements of the NEF. The reporting was required after the organization had finalized spending plans for the current fiscal year. There are no mechanisms in place to ensure that only NEF funds are reported on the Baseline Data and Quarterly Reports. There was inconsistency in the way that CCACs completed the Baseline Data and Quarterly Reports. CCACs noted that they received little feedback from the Ministry of Health and Long-Term Care on the quality of their reporting on the NEF.

It is recommended that:

(12) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should ensure that NEF data are reported consistently by all CCACs.

Implementation Issues

Timelines were very tight as the Ministry implemented the NEF. CCACs were requested to complete their application for enhanced funding in less than 4 weeks over the summer of

1999. These timelines and accountability expectations were described as unrealistic during a number of interviews. CCACs were asked to prepare Nursing Profile (CCACs and LTC facilities do not have a Nursing Plan like the hospitals) before their 1999/2000 budget was approved.

Participation in Planning and Decision-Making

The allocation of the NEF occurred retroactively under tight timelines. As a result, in some organizations, no front line staff were involved. There are, however, many examples of staff participating in planning and decision making within CCACs. Many examples were provided of other opportunities for CCAC staff to participate in operational decision-making (staff committees, etc.). For example, some CCACs reported seconding front-line staff for special projects within the organization.

1.0 Background and Introduction

1.1 Background

There are concerns regarding the future supply of professional nurses in Ontario. A 1998 study by the Canadian Institute of Health Information revealed Ontario has fewer RNs per capita than any other province - 6.9 per 1,000 people versus a national average of 7.6 pe. 1,000.[1] In addition, more than half of all professional nurses working in Ontario are employed on a part-time or casual basis. To better understand the nature of this problem, the Minister of Health and Long-Term Care established the Nursing Task Force to examine nursing services in Ontario. Specifically, the Task Force was to identify how changes in the profession have affected the delivery of nursing services, and to recommend how to improve the province's health care system through nursing services. In its report, *Good Nursing, Good Health*, the Task Force has indicated that it believes that there needs to be greater emphasis on health promotion and illness prevention, and an increased reliance on professional nursing services, such as primary care nurse practitioners.[2]

1.1.1 Nursing Task Force

The Nursing Task Force was established to examine nursing services in Ontario, to identify how changes in the profession have affected the delivery of health care services, and to recommend how the province's health system can be improved through nursing services. The Task Force was directed to examine the level of access to quality nursing services and to identify changes in nursing related to health care reform.

Nursing Task Force Recommendations

In January 2000, the Nursing Task Force issued its report, which included eight recommendations, two of which are key to this review:

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[1] Canadian Institute of Health Information (CIHI), *Public Sector Health Expenditures by Province, Territory and Canada*, 1975 - 1998, Fall 1998.

[2] *Good Nursing, Good Health : An Investment in the 21st Century* Report of the Nursing Task Force, January 2000

1. To immediately enhance health care delivery through nursing services by stabilizing the nursing workforce and improving retention of existing nursing.
2. To improve patient outcomes and the level of nursing services provided to consumers, it is recommended that ongoing structured opportunities be provided for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and operational level. In addition, health care delivery organizations must ensure that there is specific responsibility and accountability, at a senior management level, for professional nursing resources.

In response to recommendation 1, the Minister of Health and Long-Term Care announced on March 19, 1999 that the government would provide $375 million to create 12,000 new nursing positions by March 31, 2001. The Nursing Enhancement Fund commitment to nursing in 1999/2000 included creation of new, permanent full-time and part-time positions by investing:

- $130 million new base funding annually to hospitals to create 3,300 new nursing positions in 1999/2000;
- $24 million in new funding annually to in-home services of which a minimum of 60 percent was to be spent on nursing services to create 500 new nursing positions in 1999/2000; and,
- $20 million in new funding annually to Long-Term Care (LTC) facilities to create 650 new nursing positions in 1999/2000.

The remainder of the investment is allocated through new and existing programs (i.e. priority programs, Emergency room funding, etc.) as well as for basic and continuing education for nurses, nursing research, hiring nurse practitioners, and recruitment and retention strategies.

1.1.2 Nursing Enhancement Fund

The Nursing Enhancement Fund was made available to hospitals, LTC facilities and Community Care Access Centres (CCACs) in Ontario, provided that each organization develop and implement a plan consistent with the government's nursing strategy.

- Hospitals had to submit nursing plans that identified by program area, where the nursing enhancement funds were to be targeted. This requirement was described in the 1999/000 Operating Plan Requirements Section 2.3.2. Human Resources Plan. In addition, they were required to complete an MS Excel spreadsheet documenting the use of Nursing Enhancement Funds as described in their Nursing Plans.
- Operators of non-red circled LTC facilities and operational interim LTC beds were eligible for funding, provided that the operators applied for the funding and agreed to increase their RN/RPN hours.
- CCACs receiving funds were to submit a Nursing Profile, including baseline data and quarterly reports to the Ministry. Once approved, the Nursing Profile became part of the CCACs' 1999/00 budget and Service Agreement with the Ministry.

The government strongly supports the important role of nursing in the delivery of health services and in leadership and decision-making roles within the management of health care providers. Thus there is a need to ensure the proper implementation of the Nursing Task Force recommendations. To address this issue, the Ministry of Health and Long-Term Care has commissioned this review and audit of the use of 1999/00 Nursing Enhancement Funds provided to Ontario health care organizations. The purpose of this review and audit is to ensure accountability for the appropriate expenditure of these funds to improve the availability of and public access to nursing services.

1.2 Review Objectives

The specific objectives of this review have been:

- to identify how the Nursing Enhancement Fund was used versus the 1999/2000 approved nursing plans and instructions from the MOHLTC;
- to comment on the quality of the systems for reporting staff hours and positions for nursing;
- to highlight any problems or issues hospitals have in segregating the use of funds for priority programs, growth, 60-hour post-partum care, and new programs;

- to highlight any problems or issues with segregating the use of funding for nursing positions in CCACs, in light of contracted funding, and in LTC facilities, in light of envelope funding;
- to identify issues that organizations faced in implementing their 1999/00 Nursing Plans and strategies they took to address the issues; and,
- to report and comment on the opportunities the organizations provided for nurses to participate in a meaningful way in decisions that affect patient/client care on both a corporate and an operational level.

1.3 Project Report

This report provides:

- An assessment of whether the organizations complied with the Ministry requirements for eligibility and reporting of their 1999/00 Nursing Enhancement Funding, and whether they fulfilled their 1999/00 Nursing Plan commitment.
- Recommendations to the Ministry and the Joint Provincial Nursing Committee (JPNC) Implementation Monitoring Sub-committee (IMS) on how to improve the administration and accountability for the Nursing Enhancement Fund.
- Comments on the opportunities for the organizations provided for nursing (RNs and RPNs) to participate in a meaningful way in decisions that affect patient care on both a corporate and an operational level.

2.0 Methodology

2.1 Organizations Included in Review

The Implementation Monitoring Subcommittee of the Joint Provincial Nursing Committee selected a sample of organizations to be included in the review. Selection took a number of factors into consideration, including:

- Representation from each of the Ministry's seven health care program regions
- Mix of community hospitals, teaching hospitals, chronic care/rehabilitation hospitals, Long-Term Care Facilities and Community Care Access Centres
- Representative of all recipients of Nursing Enhancement Funds
- Size of NEF grant received

A sample of 30 organizations were selected for this review. The sample consisted of 16 hospitals, 7 Long Term Care Facilities and 7 Community Care Access Centres.

The table below presents the hospitals that were included in the sample:

Review of 1999/2000 Nursing Enhancement Fund: Hospitals

Name	City
Community Hospitals	
• Peterborough Civic	Peterborough
• Greater Niagara	Niagara
• Credit Valley	Mississauga
• Belleville-Quinte	Belleville
• Sudbury Regional	Sudbury
• Hotel Dieu Grace	Windsor
• Humber River Regional	Toronto
Teaching Hospitals	
• St. Joseph's Health Centre	Hamilton
• The Ottawa Hospital	Ottawa
• Kingston General	Kingston
• London Health Sciences Centre	London

• University Health Network	Toronto
• St. Michael's Hospital	Toronto
Chronic & Rehabilitation Hospitals	
• Sisters of Charity	Ottawa
• Riverdale Hospital	Toronto
• Toronto Rehabilitation Centre	Toronto

The table below presents the Long-Term Care facilities included in the sample:

Review of 1999/2000 Nursing Enhancement Fund:
Long-Term Care Facilities

Name	City
Extendicare/Peterborough	Peterborough
St. Joseph's Villa	Dundas
Allendale	Milton
Versa Care Lodge	Ottawa
Extendicare/York	Sudbury
Chelsey Park (Oxford) NH	London
City of Toronto Homes for the Aged (Castleview Wychwood)	Toronto

The table below presents the Community Care Access Centres that were included in the sample:

Review of 1999/00 Nursing Enhancement Fund:
Community Care Access Centres

Name	City
York	Newmarket
Niagara	Niagara-on-the-Lake
Peel	Brampton
Middlesex	London
Ottawa Carleton	Gloucester
Thunder Bay	Thunder Bay
Toronto	Toronto

2.2 *Data Collection*

Hospital Sector

The following data were provided by the Ministry of Health and Long-Term Care to support the review:

- MIS trial balance files and OCDM worksheets for the years1996/97, 1997/98, 1998/99, and 1999/2000 for the hospitals as well as their predecessor corporations where hospitals have merged or governance has been assumed by another hospital.
- Operating Plan and supplementary data for the specified hospitals for the fiscal years 1999/2000 and 2000/01. This includes the nursing plans.
- Year-end supplementary report files for the years 1996/97, 1997/98, 1998/99 and 1999/00.
- The February 2000 survey results on the status of 1999/00 nursing hires through the Nursing Enhancement Fund and the August 2000 survey on the report of the 1999/00 and 2000/01 use of the Nursing Fund Enhancement and supplementary material.

Long Term Care Facilities

- The 1999/00 and 2000/01 LTC annual operating submissions to the ministry including their nursing profiles, supplementary material and agreements.
- The LTC Facilities' February 2000 on the status of nursing hires through the 1999/2000 Nursing Enhancement Fund as of December 30, 1999, and the September, 2000, survey results on the use of the use of the Nursing Enhancement Fund.

Community Care Access Centres

- The 1999/00 and 2000/01 CCAC annual operating submissions to the ministry including their nursing profiles, supplementary material and agreements, and Baseline Data and Quarterly Reports.

2.2.1 Hours vs. Positions

When discussing nursing staff changes as a result of the NEF, nursing staff are often referred to in terms of "positions". Hospitals do not report to the Ministry in terms of positions; reporting to the Ministry is in terms of worked and paid hours. Also, there are different ways to define full-time, part-time, and casual nursing positions. This makes it difficult to compare the number of nursing positions between organizations. For example, a nurse may be defined by the employer as part-time, even though that individual may work the equivalent of full-time hours. Because of the inconsistencies in definitions and the absence of reporting, it was not possible to provide commentary with respect to the

quality of reporting of permanent full-time and part-time, contract, full-time and part-time, and casual RN and RPN positions and their consistency with the organizations' own definitions.

As a result of the difficulties in identifying, quantifying and comparing positions, the analytical approach used in this review and audit focused on the planned and actual "hours" worked by nursing staff. Where possible, nursing staff were identified by a specific staff category, such as RN, RPN, full-time, part-time, or casual (as defined by the organizations providing the data).

Using nursing hours as a measure also mitigated against as any potential issues regarding double counting positions by including people on leave (e.g. maternity, WSIB, etc.) and people backfilling positions.

2.3 Data Issues

Data collection and analysis presented a significant challenge during this review. Data were required from three distinct program areas from within the Ministry of Health and Long-Term Care: Hospitals, Long-Term Care and Community Care Access Centres. There were multiple data sources in each of these program areas (for hospitals, the MIS trial balances, operating plans, nursing plans, and primary data collection were used) and in many instances we have encountered difficulty in reconciling the particular data sources (for example hospital MIS Paid Hours 1999/98 versus Operating Plan actuals 1999/98).

Problems in data quality are fundamentally related to how data are input into the various reporting systems. In this review, the following system issues which effect data quality should be considered:

- inclusion of non-nursing staff (i.e.: unit clerks, unregulated workers) in the reports of hours in nursing functional centres
- Variation within and among hospitals in counting and reporting patient days
- Variation within and among hospitals in counting ER visits

- Variation within and among hospitals in counting ambulatory clinic visit statistics

2.3.1 Hospital Sector Data Issues

MIS Trial Balance Data

Although the MIS trial balance data are considered to be the most reliable for comparative purposes, there are a number of drawbacks in their use for the purposes of this study. As mentioned earlier, the MIS trial balance functional centres for nursing include hours for staff other than regulated professionals (RNs & RPNs). Although the trial balance contains mostly nursing hours, the nursing functional centres also include unit clerks, managers, and unregulated workers such as unit aides, patient service workers, etc. It is not possible to separately identify the RN and RPN positions from the non-nursing positions. It is also not possible to identify full-time, part-time and casual positions. Finally, despite attempts to standardize MIS reporting in Ontario, there are still inconsistencies within and among hospitals with respect to allocation and reporting of costs and workload. It is possible that some of this variation could be reflected in the results presented in this review.

Variation Between Data Sources

Variation exists between different data sources within the hospital sector. The following tables provide examples of the variation in paid hours between those reported in the MIS trial balance, the hospitals' nursing plans and the hours reported by hospitals in a payroll survey conducted for the purposes of this review. The table below shows the total nursing hours reported in each of the data sources for the years 1998/1999 and 1999/2000.

Comparison of Data Sources: MIS Trial Balance, Hospital Nursing Plans, and HayGroup Payroll Survey, 1998/1999 and 1999/2000[3]

Hospital Name	1998/1999 Fiscal Year			1999/2000 Fiscal Year		
	Total Paid Hours (UPP & M&O) *MIS TB*	Total Paid Hrs (RN & RPN) *2000I01 Operating Plan*	Total Paid Hrs (RN&RPN) *HayGroup Payroll Survey*	Total Paid Hours (UPP & M&O) *MIS TB*	Total Paid Hrs (RN & RPN) *2000I01 Operating Plan*	Total Paid Hrs (RN&RPN) *HayGroup Payroll Survey*
Hospital A	1,436,234	1,489,191	1,479,282	1,502,338	1,586,970	1,581,861
Hospital B	1,599,017	1,297,332	1,296,533	1,573,359	1,364,857	1,364,868
Hospital C	873,399	1,006,432	1,006,433	949,038	1,140,960	1,140,960
Hospital D	1,000,394	1,025,699	1,081,423	1,062,393	1,113,709	1,135,081
Hospital E	752,898	350,503	350,503	773,072	335,805	335,805
Hospital F	2,599,324	1,399,111	1,310,967	2,710,946	1,797,775	1,492,974
Hospital G	1,081,549	1,112,076	1,063,492	1,110,376	1,182,531	1,122,746
Hospital H	1,185,524	888,530	888,530	1,148,477	946,565	946,565
Hospital I	3,127,370	3,146,894	3,146,894	3,280,144	3,262,946	3,261,396
Hospital J	1,758,254	1,566,710	1,418,951	1,622,666	1,525,114	1,699,218
Hospital K	4,116,665	3,549,478	3,549,478	4,058,005	3,402,747	3,402,747
Hospital L	1,066,062	1,638,183	784,013	1,053,602	1,481,350	729,364
Hospital M	810,376	821,892	821,892	875,158	883,198	883,198
Hospital N	4,618,265	3,537,649	3,190,132	4,729,380	3,564,980	3,336,406
Hospital O	1,651,699	1,477,262	1,549,062	1,649,109	1,533,438	1,633,815
Hospital P	628,664	508,174	508,714	624,923	514,575	541,877

The table below shows the variation among data sources, using the MIS trial balance as a benchmark reference point. As can be seen, the two data sources that occasionally coincide are the hospitals' operating plans and payroll data. However, this is not universally true across all the participating hospitals. In cases where there are large discrepancies, these differences may be related to non-nursing staff, such as unregulated personal support workers.

[3] To enhance comparability with the Operating Plan data, the Total Paid Hours (UPP & M&O) includes data from the same functional centres identified in the operating plans. Complete FC information is contained in Appendix E.

Comparison of Data Sources:
Variation from MIS Trial Balance, 1999/2000

Hospital Name	1999/2000 Fiscal Year		
	Total Paid Hours (UPP & M&O) *MIS TB*	Total Paid Hrs (RN & RPN) *2000/01 Operating Plan*	Total Paid Hrs (RN&RPN) *HayGroup Payroll Survey*
Hospital A	1,502,338	5.6%	5.3%
Hospital B	1,573,359	-13.3%	-13.3%
Hospital C	949,038	20.2%	20.2%
Hospital D	1,062,393	4.8%	6.8%
Hospital E	773,072	-56.6%	-56.6%
Hospital F	2,710,946	-33.7%	-44.9%
Hospital G	1,110,376	6.5%	1.1%
Hospital H	1,148,477	-17.6%	-17.6%
Hospital I	3,280,144	-0.5%	-0.6%
Hospital J	1,622,666	-6.0%	4.7%
Hospital K	4,058,005	-16.1%	-16.1%
Hospital L	1,053,602	40.6%	-30.8%
Hospital M	875,158	0.9%	0.9%
Hospital N	4,729,380	-24.6%	-29.5%
Hospital O	1,649,109	-7.0%	-0.9%
Hospital P	624,923	-17.7%	-13.3%

In the above table, MIS TB reported Paid Hours is calculated by to include the sum of UPP only hours for Inpatient, LTC, Ambulatory and Emergency categories and UPP & M&O hours in the Miscellaneous category for each hospital.

2.3.2 LTC Sector Data Issues

Staffing Survey

The MOHLTC has conducted two staffing surveys of LTC facilities since the introduction of the Nursing Enhancement Fund. The surveys requested data in many areas, including total number of positions, total hours worked, number of vacancies, the estimated number of layoffs avoided with the NEF. Facilities were also given an opportunity to provide additional comments regarding difficulties in providing nursing services. The first survey examined the staffing levels at March 31, 1998, March 31, 1999, and December 31, 1999. The second survey requested data on staffing levels at March 31, 1998, March 31, 1999, and March 31, 2000. Although there was significant overlap among the data requested for the

two surveys, all but two of the surveys contained inconsistent data in most areas.

Analysis conducted by the Ministry was not provided for the purposes of this review. As a result, an analysis of the staffing survey for the LTC facility sector is not included in this review.

LTC Facility Staffing Schedules

LTC facilities were required to report on the impact of the NEF on the number of nursing and personal care hours provided. This is reported on the *Long-Term Care Facility Staffing Schedule – Nursing and Personal Care*. A number of issues must be taken into consideration when interpreting the data from these forms. First, the forms were different between April, 1999 and April, 2000, making them difficult to compare. The two key differences include the following:

- The 1999 form asks for total paid on-site hours per week, while the 2000 form asks for total annual paid on-site hours.
- The 1999 form includes case mix index, while the 2000 form does not.

2.3.3 CCAC Sector Data Issues

Baseline Data and Quarterly Reports

The only report that specifically captures NEF allocations in CCACs is the Baseline Data and Quarterly Report form. There appear to be no clear guidelines for completing Baseline Data and Quarterly reports. For example:

- Some CCACs completed the forms in entirely different fashions. For example, when asked to report "Actual YTD" spending, some CCACs reported how they spent the Nursing Enhancement Funds, and other CCACs reported spending for the total organization.
- Organizations were inconsistent in reporting expenditures. In some cases, benefits were included in the spending amounts, and not included in other job categories within the same quarterly report.

2.4 Site Visits

In order to provide a context for and obtain a greater understanding of the data received for the sample facilities, site visits were conducted to a sub-set of 12 of the 30 sample organizations.

Site Visit Selection Process

The IMS agreed to the following criteria for selecting organizations for site visits:

- Hospitals that are currently under an operational review would not be visited because of potential "study fatigue" (i.e. The Ottawa Hospital).
- At least one organization within each of the five categories (teaching hospital, community hospital, chronic/rehab hospital, LTC facility, and CCAC) should be visited. Site visits occurred at the organization in each category that received the largest amount of the nursing enhancement fund. It was recognized that this would result in the selection of several sites in the Toronto region.
- Regional representation is important. Site visits occurred in at least one organization from each of the ministry's seven health care program regions.

These organizations were considered by the IMS to be a representative sample of organizations across Ontario that received nursing enhancement funding. The sites included:

- **3 teaching hospitals**
  - London Health Sciences Centre
  - St. Michael's Hospital
  - University Health Network
- **3 community hospitals**
  - Humber River Regional Hospital
  - Peterborough Regional Health Centre
  - Sudbury Regional Hospital
- **1 rehab/chronic hospital**
  - Riverdale Hospital
- **3 Community Care Access Centres**
  - CCAC of Peel

  - CCAC Niagara
  - Durham Access to Care
- **2 LTC facilities**
  - City of Toronto Homes for the Aged (Castleview Wychwood)
  - Versa Care Lodge, Ottawa

Discussion during the site visits focused on three general areas:

- Quality of reporting on the 1999/00 Nursing Plan
- Issues in implementing the 1990/00 Nursing Plan
- Confirmation and clarification of data contained in Operating Plan submissions through examination of additional documentation, where required.

Attempts were made to interview the following individuals and groups at each site:

- Chief Executive Officer / Executive Director
- Chief Nursing Officer / Director of Client Services
- Vice President, Finance / Director of Finance
- Nursing Leader involved in hospital decision-making process
- Direct care nursing representative(s) (both RN and RPN representatives where possible)
- Other personnel, as appropriate

3.0 Findings: Hospitals

3.1 Chronology

On March 19, 1999, Premier Harris announced that the government would fund 12,000 new nursing positions by the end of 2000 – exceeding by 2,000 nurses the recommendation of the Nursing Task Force.[4] The Premier confirmed that the new funding allows the government to meet the nurse-to-population ratio of 7.6 registered nurses per 1,000 persons, as recommended by the Task Force

Also on March 19, 1999, the Minister of Health and Long-Term Care announced new funding of $130 million to "enable hospitals to employ over 3,300 new permanent nurses (full and part-time) over the next year."[5] The release stated that hospitals were expected to direct the funds to key areas such as emergency rooms, critical care units, cardiac and dialysis.

To address the need for accountability in the additional funding for nursing services provided to hospitals, the Minister stated that hospitals would be expected to provide the following:

- A Letter of Intent to develop a Nursing Plan
- The development of the hospital Operating Plan, which includes the final Nursing Plan (to be signed by the Chief Executive Officer, the Chief Nursing Officer, and the Chair of the Board of Directors).

Provision of Funding

Seventy-five per cent of the allocation was to be provided to hospitals upon receipt of a Letter of Intent to develop a Nursing Plan. The remainder of the allocation was to be flowed upon approval of the Operating and Nursing Plan.

The Minister's announcement indicated that hospitals would be asked in their Nursing Plan to:

- Ensure nurses are consulted in the development of the hospital Nursing Plan

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[4] March 19, 1999 [*press release*]: **Harris exceeds Task Force recommendation, announces 12,000 new nurses.**

[5] March 19, 1999 [*press release*]: **Nursing for hospitals.**

- Address priority needs for increased nurses in areas such as critical care, emergency care and dialysis
- Provide a breakdown of proposed changes of professional type of staff - e.g. RN, RPN
- Address stabilization of nursing and the issue of casualization, with a view to creating increased opportunities for permanent nursing positions
- Provide a breakdown of employment status - e.g. Full-time, part-time, casual
- Set out a plan to enhance the role of nurses in hospital decision-making

On April 12, 1999 hospitals received a letter from the Minister of Health and Long-Term Care informing them of their initial funding allocation for 1999/2000.[6] The letter indicated that the funding to be allocated to the hospital included recent government announcements, including

- Base adjustment
- Nursing investment
- Priority programs (where applicable)
- Temporary acute funding (where applicable)
- Additional emergency funding (where applicable)

The Minister's letter did not provide a specific breakdown of a hospitals' funding allocation. The letter indicates that the nursing investment is "designed specifically to enhance nursing ratios and reduce casualization." The letter also indicates that subject to hospital responses to the nursing investment it is anticipated that all funding will flow with either the April or May, 1999, transfers.

On April 14, 1999, hospital CEOs received a letter from Jessica Hill, Acting Assistant Deputy Minister of Health, that provided additional information about their 1999/2000 funding allocation, including the specific amount of their Nursing Enhancement Fund allocation for 1999/2000.[7] The letter states that in order to receive full annualized funding, hospitals are

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[6] Letter to hospital CEOs from Minister of Health Elizabeth Witmer, dated April 12, 1999.

[7] Letter to, hospital CEOs from Jessica Hill, Acting Assistant Deputy Minister of Health, dated April 14, 1999

required to sign and return (by April 20, 1999) a *Letter of Intent* (sample provided, see *Appendix A*) to develop a nursing plan and obtain Ministry approval of their complete 1999/2000 Operating Plan. The letter states that "the intent of the government is to increase current nursing levels by increasing permanent opportunities." The government also expects hospitals to increase nurse to patient ratios and provide increased service levels in high priority areas in the hospital.

Nursing Plan Documentation

The Nursing Plan was to be described in the hospital's 1999/2000 Operating Plan. Hospitals were required to do the following:

1. Identify the program areas that will be targeted for increased nursing staffing and the rationale used to support the decision;
2. By program area, provide the number of RNs and RPNs and their employment status (full-time, part-time, casual/agency) being considered for this enhancement;
3. Identify the established formalized nursing leadership positions in the management structure, as well as the plan to enhance nursing leadership within the organization
4. Describe the plan to involve nursing leaders in the hospital's decision-making process (for example, patient care, development and implementation of the operating plan, quality assurance programs and hiring and reporting);
5. Set out the plan to provide ongoing training and professional development opportunities to RNs and RPNs;
6. Document the consultation process the hospital undertook to involve nursing leaders and front-line RNs and RPNs in the development of the nursing plan including who was consulted and how.

On May 17, 1999 hospital CEOs received a memo from Jeffrey Lozon, Deputy Minister of Health, explaining the distribution methodologies that were used for the nursing funds.

3.2 Hospital Data Findings: Payroll Survey

A survey was conducted to determine the numbers of net new nursing positions for Registered Nurses (RNs) and Registered Practical Nurses (RPNs) by employment status (full-time, part-time, or casual) created as a result of the 1999/2000 Nursing Enhancement Fund. These type of data are not currently

available from any of the Ministry's hospital reporting systems.

Methodology

We surveyed all acute care and complex continuing care hospitals included in the review to obtain payroll data regarding their nurse staffing. The survey asked hospitals to provide their total paid nursing hours for 1998/1999 and 1999/2000 in each of the following categories:

- RN Full-time
- RN Part-time
- RN Casual
- RPN Full Time
- RPN Part Time
- RPN Casual

Data Quality Issues

The survey may not have captured all nursing positions in hospitals. For example, although the survey questionnaire asked hospitals to "include all nursing functional centres: nursing administration, nursing inpatient and ambulatory care (functional centres 712* and 713*)...", some hospitals employ nurses in other departments such as medical imaging and these would not have been captured in this survey (nor in their reporting of nursing hours through the MIS trial balance).

Summary of Findings

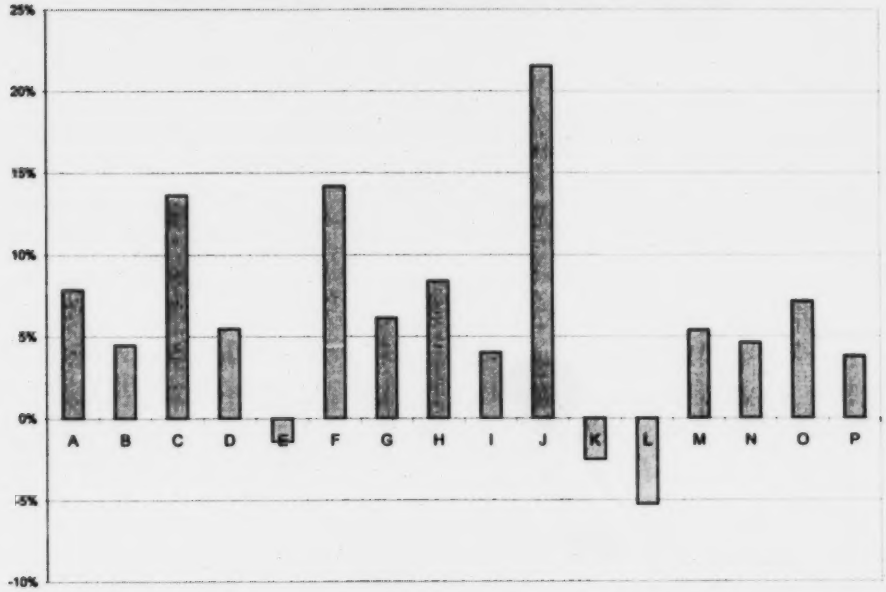
Overall, the results of the survey indicate that the total number of paid hours for nursing increased by 4.84% from 1998/1999 to 1999/2000. This increase represents approximately 582 full-time equivalent (FTE) positions in the sample hospitals.[8] Results from this target sample of hospitals may not represent all hospitals.

RN Hours

Changes in RN paid hours varied widely among the surveyed hospitals, from a 21.5% increase to a 5.3% decrease. Three hospitals reported a decrease in paid hours for Registered Nurses. The table below provides additional details on the reported changes in RN hours.

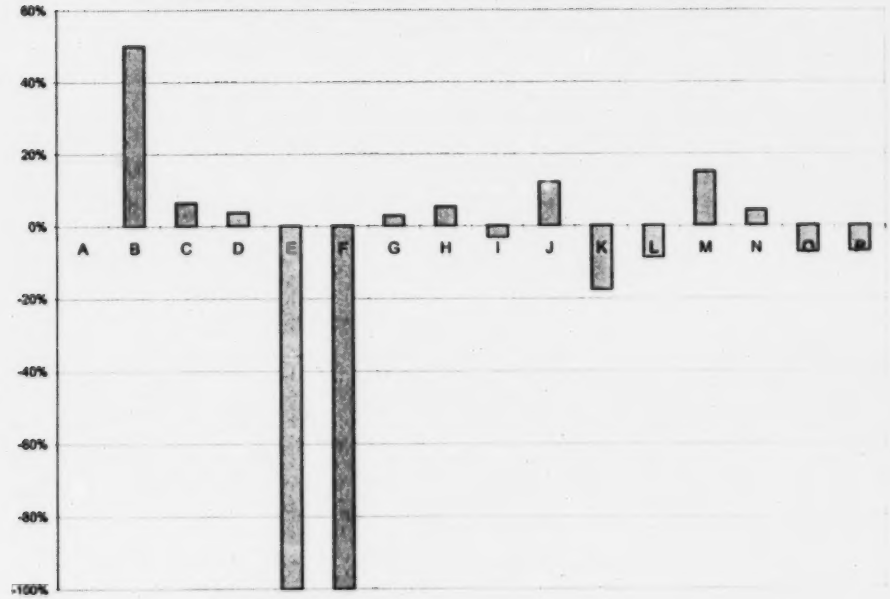
[8] Calculated using 1,950 paid hours per FTE.

Percent Change in RN Hours, 1998/1999 to 1999/2000



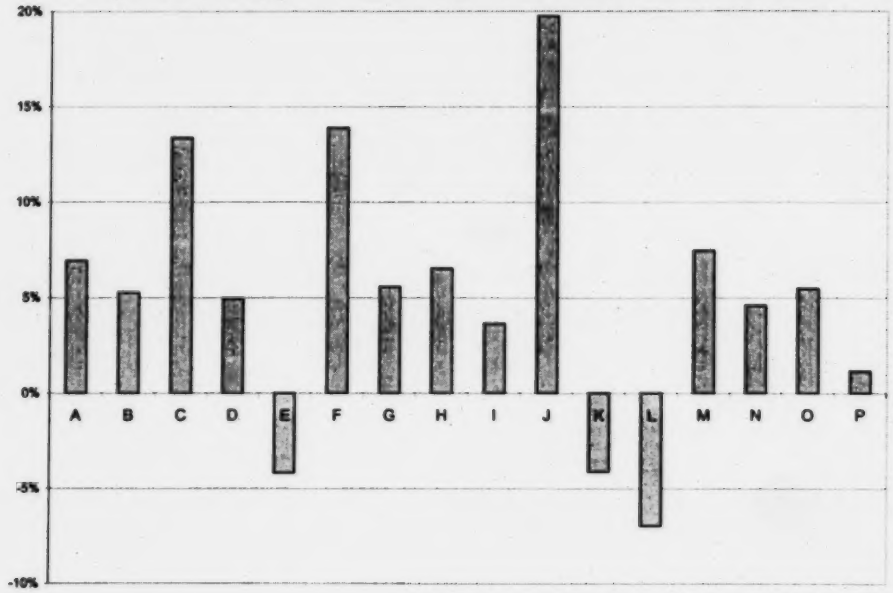
RPN Hours Changes in RPN paid hours varied even more widely among the surveyed hospitals, from a 49.9% increase to a 100% decrease. A total of eight hospitals reported a decrease in total paid hours for RPNs. In two organizations, a total elimination of the RPN role accounted for the reduction in hours from the previous year. The table below provides details on the reported changes in RPN hours.

Percent Change in RPN Hours, 1998/1999 to 1999/2000



Total Hours Three of the sample hospitals reported a net decrease in total nursing hours during the period 1998/1999 to 1999/2000.

Percent Change in Total Nursing Hours, 1998/1999 to 1999/2000



The table below shows the change in RN paid hours, RPN paid hours, and total nursing paid hours from 1998/1999 to 1999/2000 in the sample hospitals.

Percent Change in RN and RPN Hours, 1998/1999 to 1999/2000

Hospital	% Change in RN Hours	% Change in RPN Hours	% Change in Total Nursing Hours
Hospital A	7.86%	-0.02%	6.93%
Hospital B	4.47%	49.89%	5.27%
Hospital C	13.91%	6.41%	13.63%
Hospital D	5.48%	3.79%	4.96%
Hospital E	-1.42%	-100.00%	-4.19%
Hospital F	16.92%	-100.00%	16.63%
Hospital G	6.14%	2.84%	5.57%
Hospital H	8.40%	5.34%	6.53%
Hospital I	4.03%	-3.18%	3.64%
Hospital J	21.53%	12.09%	19.75%
Hospital K	-2.54%	-17.73%	-4.13%
Hospital L	-5.28%	-8.83%	-6.97%
Hospital M	5.37%	14.92%	7.46%
Hospital N	4.60%	4.28%	4.59%
Hospital O	7.15%	-7.39%	5.47%
Hospital P	3.80%	-7.12%	1.15%
TOTAL	5.86%	-0.39%	5.02%

3.2.1 Agency Nursing Hours

Hospitals were asked to report the number of earned hours for agency nursing for the years 1998/1999 and 1999/2000. The table below shows the percent change in use of nursing agency hours for RNs and RPNs. In total, the hospitals in the sample used approximately 23% more agency nursing hours in 1999/2000 compared with 1998/1999. While Hospital C reported nearly a 14-fold increase in use of agency nursing, its total of 2,861 agency hours in 1999/2000 represented less than 1% of the hospital's total nursing hours. It should be noted that in 1999/2000, use of agency hours in three hospitals represented over 75% of the total number of nursing agency hours reported in the survey.

Use of Nursing Agency Hours, 1998/1999 to 1999/2000

Hospital	Agency Hours: 1998/1999	Agency Hours: 1999/2000	% Change
Hospital A	0	0	0.0%
Hospital B	4,031	4,405	9.3%
Hospital C	196	2,861	1359.7%
Hospital D	0	0	0.0%
Hospital E	33,938	21,026	-38.0%
Hospital F	24,147	64,113	165.5%
Hospital G	0	0	0.0%
Hospital H	4,486	1,582	-64.7%
Hospital I	0	0	0.0%
Hospital J	113,691	107,021	-5.9%
Hospital K	19,066	22,525	18.1%
Hospital L	26,505	27,065	2.1%
Hospital M	0	0	0.0%
Hospital N	36,997	72,700	96.5%
Hospital O	0	0	0.0%
Hospital P	0	0	0.0%
TOTAL	263,057	323,298	22.9%

It is important to note that despite the increases in total use of agency nurses, the use of agency staff as a percent of total staff remains small.

However, hospitals also report increases in their use of nursing agency hours as a proportion of their total nursing hours. Hospitals in the sample reported that nursing agency hours represented 1.32% of their total nursing hours in 1999/2000, up from 1.12% in 1998/1999. The table below presents the trend in the use of agency hours as a percentage of total nursing hours.

Nursing Agency Hours as a Percent of Total Nursing Hours
1998/1999 to 1999/2000

Hospital	1998/1999	1999/2000	% Change
Hospital A	0.00%	0.00%	0.00%
Hospital B	0.31%	0.32%	3.81%
Hospital C	0.02%	0.25%	1184.62%
Hospital D	0.00%	0.00%	0.00%
Hospital E	9.68%	6.26%	-35.33%
Hospital F	1.81%	4.12%	127.66%
Hospital G	0.00%	0.00%	0.00%
Hospital H	0.50%	0.17%	-66.90%
Hospital I	0.00%	0.00%	0.00%
Hospital J	8.01%	6.30%	-21.39%
Hospital K	0.54%	0.66%	23.24%
Hospital L	3.38%	3.71%	9.76%
Hospital M	0.00%	0.00%	0.00%
Hospital N	1.16%	2.18%	87.89%
Hospital O	0.00%	0.00%	0.00%
Hospital P	0.00%	0.00%	0.00%
TOTAL	1.12%	1.31%	17.03%

The data presented in the above table are substantiated by feedback received during the site visit process. Hospitals reported that the use of agency staff had increased in the year 1999/2000 and more recently primarily due to the inability to recruit staff to part-time and casual pools. Organizations filled their newly created full-time positions from their part-time and casual pools, consistent with their collective agreements.

3.2.2 Overtime Hours

The difficulties that hospitals faced in recruiting new nursing staff may be resulting in increasing use of overtime hours. Increased levels of overtime are also associated with increased absenteeism among staff associated with both sick time and decreased quality of worklife in an organization. The table below shows the total use of overtime in the hospitals that participated in the survey. Overall the level of overtime hours increased 14.2% from 1998/1999 to 1999/2000. The use of overtime ranged from an 18% reduction to a 52% increase. Five organizations saw overtime increases of greater than 25%

Overtime Hours, 1998/1999 to 1999/2000

Hospital	Overtime Hours: 1998/1999	Overtime Hours: 1999/2000	% Change
Hospital A	21,200	29,010	36.8%
Hospital B	20,938	19,853	-5.2%
Hospital C	6,055	8,731	44.2%
Hospital D	49,311	51,928	5.3%
Hospital E	1,481	2,256	52.3%
Hospital F	54,245	67,711	24.8%
Hospital G	14,357	13,077	-8.9%
Hospital H	4,045	4,305	6.4%
Hospital I	16,907	21,363	26.4%
Hospital J	33,808	36,620	8.3%
Hospital K	40,044	60,331	50.7%
Hospital L	7,927	9,349	17.9%
Hospital M	9,000	10,875	20.8%
Hospital N	42,148	43,280	2.7%
Hospital O	32,956	26,856	-18.5%
Hospital P	9,768	10,246	4.9%
TOTAL	364,190	415,792	14.2%

Hospitals are also reporting increases in their use of overtime hours as a proportion of their total nursing hours. Hospitals in the sample reported that overtime hours represented 1.69% of their total nursing hours in 1999/2000, up from 1.55% in 1998/1999. The table below presents additional details.

Overtime Hours as a Percent of Total Nursing Hours
1998/1999 to 1999/2000

Hospital	1998/1999	1999/2000	% Change
Hospital A	1.43%	1.83%	27.97%
Hospital B	1.61%	1.45%	-9.93%
Hospital C	0.60%	0.76%	26.90%
Hospital D	4.56%	4.57%	0.33%
Hospital E	0.42%	0.67%	59.00%
Hospital F	4.06%	4.35%	7.03%
Hospital G	1.35%	1.16%	-13.72%
Hospital H	0.46%	0.45%	-0.10%
Hospital I	0.54%	0.66%	21.92%
Hospital J	2.38%	2.16%	-9.55%
Hospital K	1.13%	1.77%	57.16%
Hospital L	1.01%	1.28%	26.77%
Hospital M	1.10%	1.23%	12.45%
Hospital N	1.32%	1.30%	-1.82%
Hospital O	2.13%	1.64%	-22.74%
Hospital P	1.92%	1.99%	3.71%
TOTAL	1.55%	1.69%	8.71%

3.3 *Hospital Data Findings: MIS Trial Balance*

Methodology

The primary data source for the review of nursing worked and paid hours in hospitals is the MIS trial balance data as reported to the Ministry of Health and Long-Term Care. For the purposes of this analysis, we have presented total hours in both unit producing (UPP) and unit producing and management and operations (UPP + M&O) formats. There can be variation among hospitals and over time in what is reported as UPP versus M&O. As a result, for this review we have grouped UPP and M&O together.

Data Quality Issues

Although the MIS data are the only uniformly reported and edited data source suitable for this review, there are limitations to the data. The hours contained in the MIS trial balance represent mostly nursing (RN & RPN), but also include hours for clerks, managers and aides. Also, it is not possible to distinguish between RN and RPN hours in the MIS TB data.

Worked Hours

The table below shows the total worked nursing hours and the percent change for each hospital in the sample for 1998/1999 and 1999/2000.

Total Worked Nursing Hours: 1998/1999, 1999/2000

Hospital	98/99 Actual (Source:MIS)		99/00 Actual (Source:MIS)		% Change	% Change
	UPP WORKED Hrs	UPP + M&O WORKED Hrs	UPP WORKED Hrs	UPP + M&O WORKED Hrs	UPP WORKED Hrs	UPP + M&O WORKED Hrs
Hospital A	1,221,786	1,371,677	1,280,221	1,437,646	4.8%	4.8%
Hospital B	1,302,984	1,481,932	1,272,433	1,493,630	-2.3%	0.8%
Hospital C	769,709	891,593	835,958	947,140	8.6%	6.2%
Hospital D	848,772	970,641	884,532	1,012,010	4.2%	4.3%
Hospital E	644,247	661,330	672,615	688,940	4.4%	4.2%
Hospital F	2,141,578	2,545,514	2,265,957	2,704,429	5.8%	6.2%
Hospital G	907,195	1,049,919	925,870	1,072,114	2.1%	2.1%
Hospital H	1,003,101	1,112,078	966,255	1,077,022	-3.7%	-3.2%
Hospital I	2,510,664	2,980,989	2,714,305	3,178,205	8.1%	6.6%
Hospital J	1,500,378	1,534,492	1,365,519	1,595,958	-9.0%	4.0%
Hospital K	3,445,343	3,876,677	3,384,294	3,900,034	-1.8%	0.6%
Hospital L	840,730	950,135	794,510	1,003,491	-5.5%	5.6%
Hospital M	731,372	817,570	776,204	877,253	6.1%	7.3%
Hospital N	3,763,260	4,439,709	3,876,751	4,616,516	3.0%	4.0%
Hospital O	1,418,333	1,512,166	1,417,962	1,570,855	0.0%	3.9%
Hospital P	528,856	607,351	533,586	597,238	0.9%	-1.7%
Sample Total	**23,578,308**	**26,803,773**	**23,966,972**	**27,772,481**	**1.6%**	**3.6%**
Median	**1,112,444**	**1,241,878**	**1,119,344**	**1,257,334**	**2.5%**	**4.1%**

From 1998/99 to 1999/2000 there was an overall 1.6% increase in UPP worked hours and a 3.7% increase in UPP and M&O worked hours for the group of hospitals sampled.

UPP and M&O Hours

Six hospitals reported a negative change in unit-producing worked hours, but only one of those hospitals reported a negative change when unit-producing hours were combined with management and operations hours. Although they might suggest one or more of:

- an increase in orientation and training hours for staff
- an increase in specialized nursing staff such as clinical nurse specialists
- an increase in nursing management and/or support staff

given the variation in allocation and reporting of UPP and M&O hours within and between organizations, it is difficult to draw conclusions from these data with respect to the exact way in which the Nursing Enhancement Funds might have been used.

Paid Hours MIS TB Paid hours are greater than worked hours because they include sick, vacation, jury duty, professional development, etc. The following table shows total paid nursing hours (UPP and UPP and M&O) for 1998/99 and 1999/2000 and the percent change.

Total Paid Nursing Hours: 1998/1999, 1999/2000

Hospital	98/99 Actual (Source:MIS)		99/00 Actual (Source:MIS)		% Change	% Change
	UPP PAID Hrs	UPP + M&O PAID Hrs	UPP PAID Hrs	UPP + M&O PAID Hrs	UPP PAID Hrs	UPP + M&O PAID Hrs
Hospital A	1,405,753	1,574,598	1,472,443	1,653,916	4.7%	5.0%
Hospital B	1,510,349	1,714,052	1,481,007	1,736,007	-1.9%	1.3%
Hospital C	865,413	1,003,483	942,719	1,069,710	8.9%	6.6%
Hospital D	960,640	1,098,694	1,031,271	1,176,105	7.4%	7.0%
Hospital E	745,003	765,444	764,789	784,723	2.7%	2.5%
Hospital F	2,476,038	2,942,180	2,603,375	3,099,046	5.1%	5.3%
Hospital G	1,060,713	1,226,623	1,085,388	1,254,314	2.3%	2.3%
Hospital H	1,164,109	1,293,839	1,122,558	1,253,872	-3.6%	-3.1%
Hospital I	3,004,447	3,503,163	3,159,709	3,704,921	5.2%	5.8%
Hospital J	1,726,917	1,765,827	1,561,896	1,824,311	-9.6%	3.3%
Hospital K	4,053,021	4,548,661	3,998,982	4,586,884	-1.3%	0.8%
Hospital L	991,515	1,121,811	968,182	1,213,528	-2.4%	8.2%
Hospital M	793,138	892,232	842,973	957,213	6.3%	7.3%
Hospital N	4,316,610	5,098,842	4,445,283	5,294,555	3.0%	3.8%
Hospital O	1,615,733	1,725,212	1,627,877	1,800,560	0.8%	4.4%
Hospital P	601,727	692,623	603,317	675,709	0.3%	-2.4%
Sample Total	**27,291,126**	**30,967,284**	**27,711,769**	**32,085,374**	**1.5%**	**3.6%**
Median	**1,284,931**	**1,434,219**	**1,297,501**	**1,454,115**	**2.5%**	**4.1%**

In total, the UPP paid hours increased 1.57% and the UPP and M&O paid hours increased 3.75%. Five hospitals reported a reduction in unit-producing paid hours, while only one hospital reported a reduction in UPP + M&O paid hours.

These resulting changes in UPP and UPP and M&O are similar in magnitude to the change in worked hours. UPP and

M&O increased by 1,217,935 hours. This increase represents approximately 624 FTEs in the sample hospitals.

To supplement the analysis of nursing hours for this review we have examined productivity and workload using the MIS TB data. The following tables show hours per patient day (or visit) in three areas: Inpatient Acute Beds, Long-Term Beds and Emergency. The breakdown of functional centers in each of these areas follows the Ministry of Health and Long-Term Care budget reporting guidelines and are provided as an appendix.

3.3.1 Inpatient Acute Workload

The table below presents the total number of patient days for in-patient acute care. For the hospitals included in our sample, the number of in-patient days declined by a total of 1.6%.

Total Patient Days (Inpatient Acute Care): 1998/1999, 1999/2000

Hospital	1998/1999	1999/2000	% Change
Hospital A	129,957	133,128	2.4%
Hospital B	138,868	148,046	6.6%
Hospital C	94,634	95,704	1.1%
Hospital D	81,777	79,981	-2.2%
Hospital E			
Hospital F	178,462	186,752	4.6%
Hospital G	114,991	112,259	-2.4%
Hospital H			
Hospital I	236,229	237,060	0.4%
Hospital J	167,291	171,326	2.4%
Hospital K	298,094	283,138	-5.0%
Hospital L			
Hospital M	72,000	72,678	0.9%
Hospital N	412,524	391,417	-5.1%
Hospital O	163,204	150,580	-7.7%
Hospital P	61,125	52,337	-14.4%
Totals	**2,149,156**	**2,114,406**	**-1.6%**

The number of patient days has an impact on the hours of care per patient day and should be considered when analyzing the results in the table below.

The following table shows worked hours per patient day and change in worked hours per patient day for Inpatient Acute areas (Medical, Surgical, Combined Med/Surg, Pediatrics, Intensive Care, Obstetrics and Mental Health). There are no

results presented for hospitals E, H, and L because these hospitals do not have inpatient acute care beds.

Total Worked Hours per Patient Day (Inpatient Acute Care): 1998/1999, 1999/2000

Hospital	1998/1999		1999/2000		% Change	
	UPP Worked Hrs/Pt. Day	UPP + M&O Worked Hrs/Pt. Day	UPP Worked Hrs/Pt. Day	UPP + M&O Worked Hrs/Pt. Day	UPP Worked Hrs/Pt. Day	UPP + M&O Worked Hrs/Pt. Day
Hospital A	6.4	7.2	6.4	7.2	1.3%	1.1%
Hospital B	6.9	7.5	6.7	7.4	-3.2%	-1.0%
Hospital C	5.0	5.6	5.4	6.0	7.0%	6.5%
Hospital D	6.2	6.8	6.5	7.2	5.2%	6.3%
Hospital E						
Hospital F	8.9	9.8	9.1	10.0	2.4%	2.8%
Hospital G	5.7	6.3	6.0	6.6	5.0%	4.9%
Hospital H						
Hospital I	7.4	8.2	8.0	8.8	8.3%	7.4%
Hospital J	6.2	6.2	5.6	6.2	-9.3%	-0.4%
Hospital K	8.0	8.7	8.5	9.1	6.2%	4.8%
Hospital L						
Hospital M	5.8	6.4	5.8	6.5	1.0%	1.0%
Hospital N	6.8	7.5	7.3	8.2	8.3%	8.8%
Hospital O	5.9	6.2	6.3	6.8	5.7%	10.5%
Hospital P	5.4	6.1	5.9	6.4	9.2%	6.3%
Sample Total	**6.8**	**7.5**	**7.1**	**7.8**	**4.3%**	**5.2%**
Median	**6.2**	**6.8**	**6.4**	**7.2**	**5.2%**	**4.9%**

The results in the table above show that nursing hours per day in have increased by 4.2% for UPP hours and 5.3% for UPP and M&O hours. Two hospitals reported a reduction in worked hours per patient day in the acute care area.

In some instances although the total paid hours may have increased, the worked hours per patient day has decreased. This could result from an increase in patient days that exceeded the increase in worked hours, or from an increase in benefit hours that exceeded the increase in paid hours.

3.3.2 Long-Term Beds

Long-term beds include rehabilitation and complex continuing care beds in the group of hospitals sampled. These beds are located in both complex continuing care and rehabilitation hospitals, as well as some acute care hospitals. A number of hospitals in the sample do not have any long-term inpatient beds, and there are no data presented for these hospitals.

The table below presents the total number of patient days for in-patient long-term beds. For the hospitals included in our sample (with long-term beds), the number of patient days declined by a total of 0.5%.

Total Patient Days (Long-Term Beds): 1998/1999, 1999/2000

Hospital	1998/1999	1999/2000	% Change
Hospital A	8,672	9,892	14.1%
Hospital B			
Hospital C	24,820	26,217	5.6%
Hospital D	30,211	26,634	-11.8%
Hospital E	177,035	181,021	2.3%
Hospital F			
Hospital G	7,300	5,856	-19.8%
Hospital H	216,401	208,662	-3.6%
Hospital I	6,223	6,170	-0.9%
Hospital J			
Hospital K			
Hospital L	177,805	176,831	-0.5%
Hospital M	23,512	27,034	15.0%
Hospital N			
Hospital O	27,041	26,809	-0.9%
Hospital P	17,304	17,295	-0.1%
Totals	**716,324**	**712,421**	-0.5%

The number of patient days has an impact on the hours of care per patient day and should be considered when analyzing the results in the table below.

The table below shows the total worked hours per patient day and percent change in 1998/1999 and 1999/2000. The results indicate a slight overall decrease in nursing hours per patient day in the long-term bed area.

Total Worked Hours per Patient Day (Inpatient Long-Term Beds): 1998/1999, 1999/2000

Hospital	1998/1999		1999/2000		% Change	
	UPP Worked Hours	UPP + M&O Worked Hours	UPP Worked Hours	UPP + M&O Worked Hours	UPP Worked Hours	UPP + M&O Worked Hours
Hospital A	4.8	5.2	5.0	5.4	4.2%	4.3%
Hospital B						
Hospital C	3.8	4.2	4.0	4.4	4.7%	3.6%
Hospital D	4.7	5.0	5.5	5.8	17.4%	16.2%
Hospital E	3.5	3.5	3.5	3.6	2.5%	2.3%
Hospital F						
Hospital G	3.5	4.1	3.5	4.1	-0.3%	-0.3%
Hospital H	4.5	4.8	4.4	4.8	-0.8%	-0.5%
Hospital I	6.1	7.5	6.1	7.5	0.1%	0.3%
Hospital J						
Hospital K						
Hospital L	4.6	4.8	4.2	4.4	-8.0%	-8.7%
Hospital M	4.6	5.1	4.6	5.0	-0.6%	-1.7%
Hospital N						
Hospital O	4.0	4.6	4.2	4.6	3.5%	0.1%
Hospital P	4.2	4.4	4.5	4.6	5.9%	3.4%
Sample Total	**4.2**	**4.5**	**4.2**	**4.4**	**-0.8%**	**-1.3%**
Median	**4.5**	**4.8**	**4.4**	**4.6**	**2.5%**	**0.3%**

3.3.3 Emergency Services

Emergency Services was a key area for most hospitals as there was a clear increase in nursing hours per visit. Data are presented only for those hospitals with emergency departments.

The table below presents the total number of visits in the emergency department. For the hospitals included in our sample, the number of visits increased by a total of 0.2%.

Total Emergency Department Visits: 1998/1999, 1999/2000

Hospital	1998/1999	1999/2000	% Change
Hospital A	48,893	50,560	3.4%
Hospital B	50,192	52,529	4.7%
Hospital C	61,104	64,848	6.1%
Hospital D	64,478	68,125	5.7%
Hospital E			
Hospital F	65,326	67,560	3.4%
Hospital G	49,096	47,997	-2.2%
Hospital H			
Hospital I	101,941	106,551	4.5%
Hospital J	102,331	99,662	-2.6%
Hospital K	67,877	67,236	-0.9%
Hospital L			
Hospital M	112,351	113,355	0.9%
Hospital N	133,440	139,244	4.3%
Hospital O	75,196	63,571	-15.5%
Hospital P	61,343	54,758	-10.7%
Totals	**993,568**	**995,996**	0.2%

The number of ER visits has an impact on the hours of care per visit and should be considered when analyzing the results in the table below.

The table below shows a 5.1% increase in nursing UP hours per patient visit and a 9.5% increase in nursing UPP + M&O hours per visit between 1998/1999 and 1999/2000.

Total Worked Hours per Emergency Visit: 1998/1999, 1999/2000

Hospital	1998/1999		1999/2000		% Change	
	UPP Worked Hours	UPP + M&O Worked Hours	UPP Worked Hours	UPP + M&O Worked Hours	UPP Worked Hours	UPP + M&O Worked Hours
Hospital A	1.8	2.0	1.8	2.0	-2.9%	2.7%
Hospital B	1.7	2.0	1.8	2.1	4.5%	3.4%
Hospital C	1.5	1.8	1.8	2.0	13.1%	11.6%
Hospital D	1.3	1.5	1.3	1.5	5.3%	4.3%
Hospital E						
Hospital F	2.2	2.4	2.2	2.5	1.0%	3.8%
Hospital G	1.5	2.0	1.7	2.1	11.0%	8.3%
Hospital H						
Hospital I	1.5	1.9	1.5	2.0	6.4%	6.0%
Hospital J	2.3	2.4	2.1	2.6	-9.8%	11.8%
Hospital K	2.6	2.8	2.8	3.0	8.8%	8.5%
Hospital L						
Hospital M	0.9	1.0	1.1	1.2	22.3%	20.2%
Hospital N	1.7	1.9	1.6	2.0	-2.2%	2.7%
Hospital O	1.3	1.4	1.5	1.8	17.8%	30.5%
Hospital P	0.9	1.1	1.2	1.3	26.9%	23.4%
Total	**1.6**	**1.8**	**1.7**	**2.0**	**5.1%**	**9.5%**
Median	**1.5**	**1.9**	**1.7**	**2.0**	**6.4%**	**8.3%**

3.4 *Quality of Reporting*

Many hospitals reported that there were a number of initiatives in progress at the same time as NEF, such as establishing new programs, implementing mergers, allocating other targeted funding, etc. All of these things made it difficult to report NEF-specific allocations. Hospitals indicated that there is a risk of nursing enhancement funds being 'buried' within other initiatives of the province and the hospitals. Without specific tracking mechanisms, it is difficult to track changes in the status of positions created using the NEF.

Targeted Funding in a Global Budget Environment

The Ministry of Health uses a 'global funding system' to transfer most operating funds to hospitals. Hospital financial systems are not designed to separately identify or track the use of targeted funds. It is difficult for hospitals to separately identify NEF (or any other) allocations unless they are attached to an activity (program or cost centre) that they use to accumulate records of activity and/or spending. This approach is further complicated when hospitals receive multiple bundles

of targeted funding. In order to address this issue some hospitals (typically larger teaching hospitals) have developed specific tracking mechanisms to identify where positions were created and relate these individual positions to specific funding sources. In some instances, it was easier to identify positions because NEF funds were used to launch new patient care areas (nursing units, outpatient clinics, etc.).

Some hospitals expressed a fundamental concern with the use of targeted funding for specific services in a globally funded organization. There was a perception that the Ministry of Health and Long-Term Care is attempting to micro-manage the health care system and interfere in the management of individual hospitals. By funding a small portion of a hospital's nursing hours, the Ministry was attempting to control the total number of nursing hours used by the hospital in caring for its patients.

It is recommended that:

(1) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should clearly define the accountability and reporting requirements associated with targeted programs such as the Nursing Enhancement Fund in advance of distributing the funds.

Improving Reporting Requirements

The reporting expected of hospitals for NEF is different from how hospitals currently operate and report internally or externally. The current NEF reporting requirements are also a change from other Ministry reporting requirements. Adding to the level of complexity, hospitals reported that the requirements have changed between 1999/2000 and 2000/2001.

It was suggested that the Ministry might modify its MIS reporting requirements to allow for the creation of a functional centre that could be used to record NEF revenues, staffing and related expenditures. The staff hours and costs could then be allocated to operational functional centres in relation to where staff were actually used. This would enhance accountability for NEF revenues and allow hospitals to more accurately track NEF revenues and related spending.

Alternatively, hospitals in some provinces report hours and dollars in greater detail within functional centres than Ontario hospitals. Manitoba and New Brunswick are examples. The additional detail is usually based on "bargaining group", which is an easily achievable breakout. For example, an Ontario

hospital would report under one code for UPP worked hours (35010) for a functional centre. A Manitoba hospital would break out that amount into the following categories:

- 35110 - General UPP Worked Hours
- 35210 - Registered Nurse UPP Worked Hours
- 35310 - LPN UPP Worked Hours
- 35410 - HCA UPP Worked Hours
- 35510 - RPN UPP Worked Hours

This approach would enable the Ministry to track changes in all staffing categories (RN, RPN, etc.). Management and operations and benefits reporting are similarly enhanced.

New Brunswick has eight bargaining groups and currently goes to even greater detail, in which a database of HR & Payroll data is fed biweekly directly from the hospitals' payroll systems to the Ministry.

If the intent of the government's nursing policy is to protect the status of NEF funded nurses, then it should require hospitals to set up an NEF functional centre and track NEF nursing hours. However, if the intent of the government's nursing policy is to increase nursing hours overall, then it should focus on all nursing hours, not just NEF funded hours. It should track total nursing hours in the hospital and it should track these hours in greater detail. It should change the Ontario Hospital Reporting System (OHRS) to provide for sub-accounts within each functional centre. the sub-accounts should relate to RN hours, RPN hours and other staff hours. These sub-accounts could then be accumulated across functional centres to provide a meaningful representation of nursing in the hospital.

It is recommended that:

(2) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care modify the Ontario Hospital Reporting System to provide for sub-accounts within each functional centre fur use in tracking different types of nursing hours.

(3) Ontario hospitals should modify their tracking and reporting systems to provide sub-accounts within each functional centre to facilitate tracking and reporting of different types of nursing hours.

Internal Reporting

There appears to be a lack of specific reporting at the senior management level on levels of nursing staff within hospitals. While there are reports to track variances from budgeted costs of the nursing units, regular reporting of nursing hours overall, and NEF-funded positions in particular, is not widespread. To be fair, the focus of hospital management has been the management of functional centre budgets and hours, not the management of the hours of different categories of staff. Of there is to be a focus on nursing and nursing hours, there are opportunities within the hospital sector to improve internal reporting of both existing and enhanced levels of nursing. More thorough internal reporting would result in improved reporting to the Ministry of Health and Long-Term Care, and would enhance the level of accountability for the use of the NEF.

It is recommended that:

(4) The Joint Provincial Nursing Committee recommend that hospital Chief Nursing Officers and senior managers ensure a mechanism is established for monitoring variance from the planned use of Nursing Enhancement Funds.

Operating Plan Reporting

Hospitals provided different levels of detail in the Nursing Plan component of their 1999/2000 Operating Plans. There were no specific guidelines from the Ministry of Health and Long-Term Care regarding the level of information and detail required for the narrative component of the Nursing Plan.

Tracking Vacancies

Many hospitals found it difficult to track the impact of the NEF on vacancy rates because of staff fluidity within the organization. For example, the creation of new positions created temporary vacancies because of staff movement within the organization.

Also, the current nursing shortage creates a mobile workforce, allowing staff to move from organization to organization. Organizations have hired and lost staff simultaneously in this tight labour market. Many hospitals claim that although they hired new nursing staff using NEF funds, the number of nurses employed does not reflect the increased funding because of high numbers of resignations from the hospital that happened simultaneously with the hiring.

Deferring Staffing Reductions

Some organizations in a deficit position could not demonstrate the 'addition' of staff; they claimed that NEF funds were used to reduce the number of positions that would otherwise have

been eliminated. These hospitals provided estimates of positions saved.

3.5 Implementation Issues

There were several issues with the implementation of the NEF. Issues identified in our site visits are discussed briefly in the paragraphs following.

Confusion About Intent of Funds

Within the hospital sector, there was some initial confusion about intent of the new funding. There was a general sense that the funds should be able to be spent on recruitment, training, support workers, clerical staff, equipment, or any other item that improves the quality of work life for nurses.

It is recommended that:

(5) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should develop clear guidelines for the use of targeted funds at the time that new funding is announced.

Timing

During the site visits many hospitals noted that the time available for development of Nursing Plans by hospitals was somewhat short. As noted in the chronology above, the Nursing Plan requirements were announced on March 19, 1999. Hospitals were provided with additional Nursing Plan requirement details in an April 14 letter, in which hospitals were asked to submit their nursing plans by June 28, 1999. Although hospitals are large organizations and it is difficult to solicit meaningful input from all levels of staff in a short period of time, with sufficient notice of the requirement, 14 weeks is sufficient time to perform the necessary consultation to determine how best to allocate the NEF. Now that they know that this is a requirement, hospitals should not have a problem in preparing their nursing plans in a timely fashion.

Although hospitals expected their plans to be approved by July 26, formal approval (and the balance of the funding) was not received until the fall of 1999.

The timing of receipt of funds was problematic for many organizations. Receiving the funds in September made it difficult and in some cases impossible to spend all the funds before the end of the fiscal year without setting a running rate of spending nursing staff that was not sustainable by the NEF

funding. As a result, some hospitals used these monies for purposes other than full-time nursing positions.

It is recommended that:

(6) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should ensure that annualized funds are received by hospitals at the beginning of the fiscal year in which they are required to be allocated.

Using NEF to Improve Quality of Work Life for Nurses

Many hospitals that were unable to use all of the NEF allocation to hire additional nursing staff in 1999/2000 used the remainder for one-time nursing-related expenditures, such as educational programs and professional development. Hospitals that could not use all of the funds allocated to professional development because they were only able to start the process halfway through the fiscal year, used the remainder of these funds for equipment to support direct nursing care, (e.g. beds, thermometers, etc.) that staff had identified as important in improving the quality of work life.

Staff Recruitment

Hospitals took different approaches to the timing of staff recruitment. Some organizations waited until final approval from the Ministry was received before beginning recruitment. Some organizations proceeded with hiring in anticipation of final approval, as there were some positions that would have been filled regardless of whether their Nursing Plans were approved by the Ministry. This occurred despite the fact that hospitals received 75% of the expected NEF allocation after completing a letter of intent to develop a nursing plan.

Also, because of the way dollars were flowed, there was a perception that all employers were recruiting for new nursing staff at the same time. An infusion of funds all at once had the effect of inflating demand for nursing staff.

Recruiting Practices

The provision of funds to hire additional nurses, combined with a shortage of available staff prompted many hospitals to use aggressive, "private-sector" recruitment techniques. A number of hospitals commented on experiencing higher than expected costs to recruit nursing staff to fill new positions. Significant effort was required from human resources staff and nursing managers to recruit qualified candidates. Many organizations, including hospitals and CCACs reported making attempts at regional human resources planning and conducting joint recruiting efforts such as job fairs in an

attempt to reduce recruiting costs and avoid direct competition for new staff.

It is recommended that:

(7) The Joint Provincial Nursing Committee should encourage and facilitate regional and collaborative nursing human resources planning and recruiting efforts.

Nursing Shortages

Many organizations reported that they had difficulty in recruiting nurses. The causes of the nursing shortage are complex and multi-factorial. Some of the reasons for recruitment difficulties that were cited by hospitals include a preference for experienced nursing staff, implementation of different models of care, quality of worklife and working conditions, and a supply/demand mismatch with respect to training in clinical specialty areas.

Impact of New Staff on Hospitals

New positions were often filled through the movement of internal staff from part-time positions into full-time positions. This had the effect of creating shortages in the part-time and casual staff pool for many hospitals.

In some organizations, front-line and management nurses reported difficulties with the technical competencies of new recruits. Staff orientation and training to integrate new nurses into the care processes and organizational culture of a hospital takes time, but it is required to maintain quality of patient care.

Nurses Expressing a Preference for Casual / Part-time Employment

Many organizations created new full-time positions. Also, some hospitals found that they had greater flexibility if they used full time staff to work in 'float pools' who were assigned to different nursing units in response to fluctuating workload. However, many organizations are finding that nurses are beginning to prefer casual positions in this "shortage" environment. 'Casual staff' are better able to set their own work schedule and can make more money by working in more than one organization.

Staff Retention

Retention of nursing staff was cited as a problem in all organizations visited as part of this review. In an effort to retain nursing staff, some organizations have enhanced professional development and educational opportunities for nurses. These initiatives are seen to be important by direct care providers.

Hospitals' Concerns with MOHLTC Management of NEF

Some frustration was expressed by hospitals with the allocation formula. It was felt by some that hospitals that had previously cut nurses benefited more from the allocation formula than those hospitals that had not reduced nurse staffing levels. Hospitals that reduced their cost per weighted case by reducing staff received proportionately more Nursing Enhancement Funds than those organizations that maintained levels of nursing care.

Some hospitals expressed concern with the limited amount of involvement of Chief Nursing Officers in the province in helping the Ministry to establish priorities for funding.

There was a lack of clear direction from the Ministry regarding reporting requirements when the funding was first announced. It was felt that hospitals should have had more input on developing the reporting requirements that accompanied the NEF.

It is recommended that:

(8) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should consult stakeholders and end-users when developing new reporting systems in all sectors (such as Chief Nursing Officers and Finance Director).

Long-Term Impact of NEF

On nursing units where positions were added, direct care staff were aware of the changes, were appreciative of the impact of the new positions on the quality of both patient care and nursing work-life and they attributed the changes to NEF. Other front-line staff (in areas that did not receive additional positions) were unaware of the NEF allocation to their hospitals or of how the NEF dollars were allocated. In these organizations, it might be appropriate to share information about receipt and application of NEF with all nursing staff.

Most individuals that were interviewed during the site visit process had difficulty attributing the impact of NEF-related changes to lasting effects within their organizations. Other circumstances have overshadowed the improvements in staffing ratios (i.e., ER overcrowding, increased complexity of cases, nursing staff shortages, etc.).

3.6 *Participation in Planning and Decision-Making*

When hospitals were asked to prepare a Nursing Plan as part of the 1999/2000 Operating Plan, they were asked to do the following:

- Describe the plan to involve nursing leaders in the hospital's decision-making process (for example, patient care, development and implementation of the operating plan, quality assurance programs and hiring and reporting);
- Document the consultation process the hospital undertook to involve nursing leaders and front-line RNs and RPNs in the development of the nursing plan including who was consulted and how.

Nursing Participation in Allocating NEF

In summary, the range of level or participation for front-line staff varied among sites that were visited as part of this review. Across all sites, there generally appeared to be a commitment to involving nursing staff in decision-making.

Some hospitals struck large committees with broad representation of all levels of nursing including front-line staff and bargaining unit representation. These processes were open to all staff and there was a significant communication effort to inform individuals not directly participating in the process of the results. These committees determined how and where new positions were to be allocated, according to needs within the hospital and based upon the input of their peers. In some cases, these committees had decision-making authority with respect to the use of the funds.

One hospital made use of staff surveys, which had high response rates to obtain input from nursing staff regarding the most appropriate use of the NEF

In hospitals with deficits, there was less involvement of front-line staff, though in some cases bargaining unit representatives met with management about the deficit issues.

In a small number of instances, direct care providers were not really involved in the planning process. As mentioned earlier, a number of different approaches to informal consultation were used:

- Reliance on middle and senior level managers (most of whom are nurses) for input to identify needs, changes in patient acuity and/or education requirements;

- Plan development by the Chief Nursing Officer and circulation to managers and staff for feedback and input;
- Staff surveys.

Nursing Participation in Hospital Management

The report of the Nursing Task Force, *Good Nursing, Good Health*, recommended that "on-going structured opportunities be provided for RNs and RPNs to participate in a meaningful way in decisions that affect patient care on both a corporate and an operational level". While increasing staff involvement in decision-making was not a criteria for receiving nursing enhancement funding, a number of hospitals reported successfully using new approaches to consulting with staff and involving staff. The level of staff participation in the ongoing management of hospitals has increased in recent years; however, hospital managers and direct care providers were hesitant to attribute this change to the NEF. The level of staff participation in management and decision-making appears to be more strongly associated with organizational culture than with additional spending.

3.7 Other Site Visit Findings

A wide range of additional feedback was received during the hospital site visits. Comments included the following:

- There is a perception among some that resources were thrown at nursing problems without addressing systemic issues. For example, some hospitals identified the need to hire non-nursing patient care workers to free up nurses to do their jobs. However, they interpreted the instructions to indicate that this would not be an acceptable use of the NEF.
- There was also a concern that by requiring hospitals to use the NEF funds to increase nurse staffing; the Ministry was also indirectly attempting to force hospitals to maintain historic levels of nurse staffing. Such a requirement, along with other directives not to reduce spending on mental health or laboratory services, will severely limit hospitals' ability to respond to changes in patient volume, costs of labour and supplies or revenue in order to maintain an operating surplus.
- There is a need to reduce stress on nurses by adding more beds into the hospital system, thereby reducing pressure to complete the process of care and discharge patients earlier.

- Senior nurses are being burnt out. There is still a sense that they are working short-staffed without proper equipment and feeling that no one is listening to their concerns.

3.8 Fulfillment of Nursing Plan Commitments

Data Sources

Given all of the caveats and data quality notes provided throughout the review and audit, it is important to take information from all of the available data sources into consideration. Without NEF-specific data reporting requirements in the hospital sector, all of the available data, plus primary data collection, are required to deduce a hospital's use of the NEF.

As part of the 1999/2000 Operating Plan, hospitals were required to prepare a Nursing Plan that described how the NEF would be spent in their organization. The table below shows whether hospitals' 1999/00 Nursing Plans provided for on increasing or decreasing the number of nursing hours from 1998/99 to 1999/00. The hospitals included in the review and audit reported a planned increase in nursing hours of 5.4%

Planned Increase or Decrease in Nursing Hours in Hospital Nursing Plan: 1998/1999 to 1999/2000

Hospital	RN	RPN	Total Nursing
Hospital A	7.6%	-9.4%	5.6%
Hospital B	4.7%	41.2%	5.3%
Hospital C	29.8%	4.6%	28.9%
Hospital D	0.5%	8.6%	2.8%
Hospital E	11.1%	-100.0%	8.0%
Hospital F	57.1%	439.7%	58.7%
Hospital G	12.9%	-37.1%	4.7%
Hospital H	-6.1%	-1.4%	-3.2%
Hospital I	-4.6%	-8.3%	-4.8%
Hospital J	1.3%	-22.6%	-3.3%
Hospital K	6.3%	-24.1%	3.1%
Hospital L	-46.7%	-43.5%	-45.1%
Hospital M	5.2%	-7.8%	2.3%
Hospital N	4.4%	-0.4%	4.2%
Hospital O	30.0%	141.1%	44.5%
Hospital P	8.1%	-30.2%	-1.2%
TOTALS	7.9%	-9.4%	5.4%

In order to determine whether hospitals' Nursing Plans were achieved, the 1999/00 Nursing Plan was compared with the "1999/00 Actual" section of the 2000/01 Nursing Plan. The table below presents a breakdown of the nursing hours planned for 1999/00 (as reported in the 1999/00 Nursing Plan) and the actual paid nursing hours for 1999/00 (as reported in the 2000/01 Nursing Plan).

Comparison of Nursing Plan with Actual Results

Hospital	99/00 Planned (Source:1999/2000 Revised Nursing Plans)			99/00 Actual (Source: 2000/2001 Revised Nursing Plans)		
	RN	RPN	Total Nsg	RN	RPN	Total Nsg.
Hospital A	1,416,249	156,973	1,573,222	1,414,836	172,134	1,586,970
Hospital B	1,334,056	32,224	1,366,280	1,330,639	34,218	1,364,857
Hospital C	1,257,904	39,182	1,297,086	1,101,107	39,853	1,140,960
Hospital D	731,022	323,686	1,054,708	821,717	291,992	1,113,709
Hospital E	378,579	0	378,579	335,805	0	335,805
Hospital F	2,188,909	31,568	2,220,477	1,788,379	9,396	1,797,775
Hospital G	1,049,915	114,516	1,164,432	995,241	187,290	1,182,531
Hospital H	325,167	534,877	860,044	375,247	571,318	946,565
Hospital I	2,840,308	155,897	2,996,205	3,096,819	166,127	3,262,946
Hospital J	1,279,064	235,619	1,514,682	1,249,482	275,632	1,525,114
Hospital K	3,377,950	283,262	3,661,212	3,095,748	306,999	3,402,747
Hospital L	449,315	449,661	898,976	799,848	681,503	1,481,350
Hospital M	675,398	165,564	840,962	676,739	206,459	883,198
Hospital N	3,532,300	153,900	3,686,200	3,334,971	230,009	3,564,980
Hospital O	1,667,860	467,496	2,135,356	1,365,555	167,883	1,533,438
Hospital P	415,974	85,965	501,939	400,142	114,433	514,575
TOTALS	**22,919,969**	**3,230,390**	**26,150,359**	**22,182,275**	**3,455,246**	**25,637,521**

The table below presents an analysis of the degree to which hospitals were able to achieve their Nursing Plan commitments for 1999/00. The table shows the extent to which the actual nursing hours in 1999/00 were above or below the levels planned in the approved 1999/00 Nursing Plan. Nine of the 15 hospitals for which data are available reported 1999/00 actual paid hours that were equal to or greater than those committed to in the 1999/00 Nursing Plan.

Comparison of Nursing Plan with Actual Results

Hospital	RN	RPN	Total Nursing
Hospital A	-0.1%	9.7%	0.9%
Hospital B	-0.3%	6.2%	-0.1%
Hospital C	-12.5%	1.7%	-12.0%
Hospital D	12.4%	-9.8%	5.6%
Hospital E	-11.3%	0.0%	-11.3%
Hospital F	-18.3%	-70.2%	-19.0%
Hospital G	-5.2%	63.5%	1.6%
Hospital H	15.4%	6.8%	10.1%
Hospital I	9.0%	6.6%	8.9%
Hospital J	-2.3%	17.0%	0.7%
Hospital K	-8.4%	8.4%	-7.1%
Hospital L	78.0%	51.6%	64.8%
Hospital M	0.2%	24.7%	5.0%
Hospital N	-5.6%	49.5%	-3.3%
Hospital O	-18.1%	-64.1%	-28.2%
Hospital P	-3.8%	33.1%	2.5%
TOTALS	-3.2%	7.0%	-2.0%

Overall, although the total number of nursing hours increased from 1998/99 to 1999/00, the total hours did not reach the commitments of the hospitals' Nursing Plans. Hospitals overall reported that they provided 2% fewer nursing hours than they committed to in their Nursing Plans.

Every hospital that received Nursing Enhancement Funding had difficulty in fully implementing their nursing plan before the end of the fiscal year. A number of themes have been identified through the data analysis and hospital site visits that contributed to some hospitals' inability to achieve their nursing plan. These themes have been reported throughout the review and audit, and include:

- Difficulty recruiting new staff
- Timing of the receipt of the NEF
- Reluctance to hire staff beyond a running rate sustainable by the NEF

Some organizations reported that the NEF assisted them in avoiding layoffs within their organization. It is not possible to infer from the data collected whether or not this occurred.

4.0 Findings: Long-Term Care Facilities

4.1 Chronology

Ministers' Announcement

On March 17, 2000, Long-Term Care Minister Cam Jackson and Health Minister Elizabeth Witmer announced $20 million in annual funding to increase the number of front-line nurses available in long-term care centres.[9]

On June 30, 1999, Operators of Non-Red Circled LTC facilities and Operators of operational Interim LTC Beds received a letter from the Director of the Regional Branches explaining the details of the Nursing Enhancement Fund. It was stated that the NEF represented "additional ongoing funding to enhance support for professional nursing staff paid through the long-term care 'Nursing and Personal Care' envelope." LTC facilities were eligible for funding provided that the operators agreed to enhance their RN/RPN hours related to these beds and apply for the funding.

Eligible operators with less than 65 beds and eligible operators with 65 or more beds that provide 24-hour on-site RN coverage (168 hours over seven days) must spend all of the funding to increase RN and/or RPN hours.

Eligible operators with 65 or more beds that do not provide 24-hour on-site RN coverage were informed that they must use their best efforts to spend all of the funding to increase the number of hours that RN service is available in a 24-hour period. Once such an operator achieves 24-hour RN coverage, the operator must spend all of the remaining funding to increase the number of RN and/or RPN hours.

Letter of Agreement and Nursing Profile

In order to receive the funds, eligible operators operating interim beds who were interested in receiving the funding were required to complete a nursing profile and submit a signed Letter of Agreement to the Ministry by July 23, 1999. The nursing profile describes the nursing role in long-term care facilities and interim beds and how the increased RN/RPN funding is to be directed to enhance nursing care. Templates for both the Letter of Agreement and Nursing Profile were included in the June 30, 1999 letter.

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[9] March 17, 1999 [*Press Release*] **More nurses for long-term care centres**

Level of Funding To enable eligible operators to plan for and implement the staffing increases immediately, a monthly cash flow of $0.94 per resident-day based on a CMI of 100 began in May, 1999, which included a retroactive adjustment to April 1, 1999.

Accountability Operators were advised that the funding would be reconciled through the annual reconciliation process and that the staffing schedule would form a part of the reconciliation process. The reconciliation would be designed to ensure that RN/RPN hours per resident-day had increased as proposed in the staffing schedule.

4.2 Long-Term Care Data Findings

The tables below shows the change in staffing levels at selected Long-Term Care facilities in Ontario. In the six locations included in the sample, total nursing hours increased by 27,573 hours, or approximately 6.9%.

Change in Paid Hours in LTC Facilities: 1998-1999 to 1999-2000

LTC Facility	Hours Change from 99 to 00			% Change from 99 to 00		
	RN	RPN	TOTAL	RN	RPN	TOTAL
Facility A	0	2,496	2,496	0.0%	14.4%	5.6%
Facility B	1,933	19,057	20,990	3.5%	30.4%	17.9%
Facility C	-3,900	3,172	-728	-15.9%	19.8%	-1.8%
Facility D	1,950	0	1,950	8.5%	0.0%	3.0%
Facility E	-6,979	2,833	-4,146	-20.3%	8.3%	-6.1%
Facility F	4,680	2,340	7,020	21.4%	5.7%	11.2%
TOTAL	-2,316	29,898	27,583	-1.2%	14.1%	6.9%

The table below shows that the increased number of nursing hours represents a net increase of approximately 14 full-time equivalent nursing positions.[10]

FTE Changes in LTC Facilities: 1998-1999 to 1999-2000

LTC Facility	Change in FTE			% Change in FTE		
	RN	RPN	TOTAL	RN	RPN	TOTAL
Facility A	0.0	1.3	1.3	0.0%	14.4%	5.6%
Facility B	1.0	9.8	10.8	3.5%	30.4%	17.9%
Facility C	-2.0	1.6	-0.4	-15.9%	19.8%	-1.8%
Facility D	1.0	0.0	1.0	8.5%	0.0%	3.0%
Facility E	-3.6	1.5	-2.1	-20.3%	8.3%	-6.1%
Facility F	2.4	1.2	3.6	21.4%	5.7%	11.2%
TOTAL	-1.2	15.3	14.1	-1.2%	14.1%	6.9%

[10] Calculated using 1950 hours per FTE

4.3 Quality of Reporting

The tracking and reporting of the NEF in LTC facilities is fairly straightforward due to the relatively small amount of funding allocated to each facility and the relatively small number of RN or RPN nursing staff employed. In the two sites visited by the consulting team, NEF positions were tracked separately through the usual payroll mechanisms.

NEF spending needs to be reported separately to the Ministry. The sites commented that it would be much simpler to incorporate the NEF into existing reports. While this may not seem significant, LTC facilities have relatively few administrative support resources; it is difficult to absorb additional reporting requirements. Another issue for LTC facilities is the requirement to report NEF funds on a fiscal year basis, while the calendar year is used for all other reporting.

It is recommended that:

(9) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should integrate NEF reporting with other reporting requirements in the LTC sector to ease the burden on the limited administrative staff.

It should be noted that there are different bargaining unit classification systems in existence in the various facilities. For example, at one site, "full-time" and "part-time" are defined as "permanent" and "non-permanent" (or contract) staff, respectively. The terms have no relationship to the number of hours worked. At the second site, part-time is defined as 30 hours bi-weekly or less; there is no "casual" designation for RNs.

4.4 Implementation Issues

The most significant implementation issues reported by the two sites are recruitment and retention of nursing staff. Both sites used a variety of recruitment strategies, including advertising, internet, job fairs, and recruiting students.

Clearly, LTC facilities must compete for available nurses with other health providers. However, they feel that there is not a "level playing field" with hospitals. The latter typically offer higher wages as well as signing bonuses.

Recruitment and retention problems have been exacerbated because, for LTC facilities, the Ministry has treated the NEF as one-time annual funding, requiring an annual application process. Even though the Minister's announcement stated that the funding would be "ongoing", the two sites have found it difficult to recruit new staff, as they are unable to make a commitment of more than one year at a time. When nurses are hired on these terms, they leave for permanent jobs that become available in hospitals. Both sites reported turnover in the NEF-funded positions. Funding for NEF positions should be at least as predictable as funding for other staff positions in the facility. It was also pointed out that the inability to hire permanent staff into these positions reduces the impact of the NEF on the quality of care provided to residents.

It is recommended that:

(10) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should include the Nursing Enhancement Fund as a separate and permanent line item in the nursing and personal care funding envelope of long-term care facilities.

4.5 Participation in Planning and Decision-Making

Both sites visited are part of larger corporate entities. In both cases, for the most part, planning and decision-making regarding NEF took place at "head office". Nevertheless, both provided opportunities for input from facility nurses at both management and front-line levels.

Input from nurses at regular team meetings and in general meetings with the Director of Nursing was taken into consideration in developing plans. Further, management and front-line nurses were consulted in evaluating the changes that were made. At both sites, all nurses interviewed commented favourably with regard to the additional nurses and their roles, and believed that resident care had been noticeably enhanced.

4.6 Other Findings

Use of NEF Funds

One site used NEF funds to hire additional RPN hours on all units. This provided more RPNs at the bedside and allowed RNs to deal with more appropriate clinical matters. The second site added two full-time RNs: one is assigned to the Alzheimer unit; the other serves as a nurse clinician for the

entire facility. As noted above, in both cases, facility nurses are very pleased with the results and believe that resident care has improved.

Facilities would prefer greater flexibility

Both sites would prefer greater flexibility in the use of funds in order to enhance resident care. They believe that funds should be rolled into the nursing and personal care envelope base. Other identified uses for funding include:

- Hiring Personal Care Assistants to free up RNs and RPNs to fulfil their professional roles;
- Retaining external resources to provide staff education; and,
- Purchasing equipment to support nursing activities.

5.0 Findings: Community Care Access Centres

5.1 Chronology

Ministers' Announcement

On March 16, 2000, Long-Term Care Minister Cam Jackson and Health Minister Elizabeth Witmer announced $45 million in new annual funding (with approximately $40 million being made available in the first year) to support additional community care nurses, and homemaking, personal support and therapy services in Ontario's Community Care Access Centres (CCACs).[11]

This $45 million includes $27 million annually for expanded in-home nursing services, and $18 million annually for homemaking, personal care and therapy services.

Funding Letter

On April 21, 1999, CCAC Board Chairs and Chief Executive Officers were advised of the level of funding to be provided in 1999/2000. The letter outlines the change in funding from the 1998/1999 budget and separately identifies the amount that is the agencies' share of the $45 million Nursing Enhancement Fund. The letter states that the conditions under which CCACs may spend the NEF will be sent under separate cover.

Use of NEF

A July 15, 1999, memo advised CCAC Chief Executive Officers the conditions by which Nursing Enhancement funds could be used in their organizations. The memo indicated that funds "may be used to increase or enhance any client service, including nursing, case management, placement coordination, homemaking, therapies, etc." The letter noted that a minimum of 60% of the funding was to be directed to RNs and RPNs and up to 40% to other disciplines providing client services. CCACs were the only sector that was able to spend its NEF allocation on non-nursing services.

CCACs were advised that the funds were allocated according to the equity formula and were cash-flowed on a pro-rated basis. These funds are annualized and form part of the base budget of the organization.

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[11] March 16, 1999 [*Press Release*] **More new money for community care nurses.**

Accountability Expectations

The July 15, 1999, memo described added expectation of accountability for these funds along with added reporting requirements:

- The Nursing Profile was intended to describe the nursing role in community agencies and to describe how the increased RN/RPN funding is to be directed to enhance nursing service.
- The Baseline Data and Quarterly Report captures data on all expenditures related to the fund. CCACs are expected to submit a baseline report and quarterly reports on the actual use of the funds.

Templates for both the Nursing Profile and Baseline Data and Quarterly Report were attached to the memo.

5.2 CCAC Data Findings

The table below shows the allocation of Nursing Enhancement Funds in CCACs, according to the Baseline Data and Quarterly Reports for 1999/2000. According to the Baseline Data and Quarterly Reports, three CCACs spent the NEF as planned. While all CCACs increased spending in nursing from 1998/1999 to 1999/2000, these increases may not be apparent from the Baseline Data and Quarterly Reports. Some CCACs were not able to allocate the NEF as planned due to reductions in client volumes and/or nursing agencies' inability to meet demand for service.

Allocation of Nursing Enhancement Funds in CCACs

CCAC	Total NEF Allocation	Case Management	Placement Coordination	Purchased Nursing Services	Non-Nursing Purchased Services	TOTAL	Variation From Planned Allocation
CCAC A	$3,531,646	$1,407,786	$85,338	$2,359,310	$4,583,726	$8,436,160	139%
CCAC B	$2,317,593	$396,326	($361,400)	$1,880,707	$1,146,731	$3,062,364	32%
CCAC C	$4,124,705	$1,803,930	$0	$956,731	$767,291	$3,527,952	-14%
CCAC D	$1,356,946	$0	$0	$220,326	$786,167	$1,006,493	-26%
CCAC E	$2,594,936	$809,040	$49,931	$738,344	$0	$1,597,315	-38%
CCAC F	$398,981	$0	$0	$398,981	$0	$398,981	0%
CCAC G	$2,714,170	$0	$0	$2,714,170	$0	$2,714,170	0%
TOTAL	$17,038,977	$4,417,082	($226,131)	$9,268,569	$7,283,915	$20,743,435	22%

5.3 Quality of Reporting

It was noted by a number of participants during the site visits that the reporting requirements of the NEF are not consistent with how CCACs operate or other systems that are currently in

place. The Baseline Data and Quarterly Reports are the only way to track the use of the NEF.

Although the Nursing Enhancement Fund reporting requirements may be inconsistent with other Ministry of Health and Long-Term Care requirements, the Baseline Data and Quarterly Reports provided more detail than hospital sector reporting.

It is recommended that:

(11) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should integrate NEF reporting with other CCAC reporting requirements.

It was suggested that the current methods of accountability do not appear to meet the Ministry's objectives. For some organizations, the Baseline Data and Quarterly Reports were only a mathematical exercise to satisfy the requirements of the Nursing Enhancement Fund. Articulation of the reporting requirement happed after the organization had finalized spending plans for the current fiscal year. Precise allocations were not considered to be important during a year in which CCAC volumes and funding increased at a rate much higher than their NEF allocation. There are no mechanisms in place to ensure that only NEF funds are reported on the Baseline Data and Quarterly Reports.

It is noted that some CCACs completed the forms in entirely different fashions. For example, when asked to report "Actual YTD" spending, some CCACs reported how they spent the Nursing Enhancement Funds, and other CCACs reported spending for the total organization. CCACs noted that they received little feedback from the Ministry of Health and Long-Term Care on the quality of their reporting on the NEF.

It is recommended that:

(12) The Joint Provincial Nursing Committee recommend that the Ministry of Health and Long-Term Care should ensure that NEF data are reported consistently by all CCACs.

Site visit participants noted that the current reporting requirements do not necessarily represent a burden for the organizations.

5.4 Implementation Issues

Timelines were very tight as the Ministry implemented the NEF. CCACs were requested to complete their application for enhanced funding in less than 4 weeks over the summer of 1999. These timelines and accountability expectations were described as unrealistic during a number of interviews.

CCACs were asked to prepare Nursing Plan before their 1999/2000 budget was approved.

Different Allocation Approaches

CCACs took a number of different approaches in allocating the NEF within their organization. Some organizations allocated all of the funding to case management, some allocated all of the funding to purchased nursing services, and some split the funding equally or proportionately to all of the services that were eligible for enhancement with the funding. As mentioned earlier, the way in which the NEF was allocated according to the Baseline Data and Quarterly Reports was both arbitrary and difficult to verify given the large increase in total CCAC funding from 1998/1999 to 1999/2000.

It was reported that the Ministry provides too little information to CCACs, too late to be helpful. Site visit participants reported having a number of unanswered questions regarding NEF reporting requirements. For example, it was not yet known how long into the future CCACs will have to account for positions created with the NEF.

Site visit participants expressed uncertainty regarding the usefulness of completing the Nursing Profile given the nature of their service delivery model.

5.5 Participation in Planning and Decision-Making

In some cases, it was reported that the allocation of the NEF was a mathematical exercise. The allocation occurred retroactively under tight timelines. As a result, in some organizations, no front line staff were involved.

In 1999/2000, there was little opportunity for staff to participate in committees or other decision-making bodies. This could be related to the relative youth of CCACs as an organization. CCAC management recognize the need for improvements, but service delivery pressures in an unfamiliar environment have taken priority. CCACs have only recently been able to begin to focus on internal organizational improvements, such as staff empowerment.

There are, however, many examples of staff participating in planning and decision making within CCACs. Many examples were provided of other opportunities for CCAC staff to participate in operational decision-making (staff committees, etc.). For example, some CCACs reported seconding front-line staff for special projects within the organization.

Appendix A: Implementation Monitoring Subcommittee

Membership of the Implementation Monitoring Subcommittee:

Co-Chairs: Doris Grinspun, Executive Director
Registered Nurses Association of Ontario

Peter Finkle, Director, Eastern Region
Ministry of Health & Long-Term Care

Members Dr. Betty Cragg, Director, School of Nursing
University of Ottawa.
Council of Ontario University Programs In Nursing

Liane Jeffs, Senior Policy Analyst
The Nursing Secretariat, Ministry of Health & Long-Term Care

Kathleen MacMillan, Provincial Chief Nursing Officer
The Nursing Secretariat, Ministry of Health & Long-Term Care

Dr. Linda O'Brien-Pallas, Chair in Nursing Human Resources, Professor & CHSRF/CIHR
Co-Principle Investigator, Nursing Effectiveness Utilization and Outcome Research Unit (NRU)
Faculty of Nursing, University of Toronto

Jo Ann Plummer
Practical Nurses Federation of Ontario

Paul Reinhart, Director of Corporate Services,
College of Nurses of Ontario

Margaret Ringland
Ontario Association of Non-Profit Homes & Services for Seniors

Shirlee Sharkey, President
Registered Nurses Association of Ontario

Barbara Thornber, Former Executive Director
Registered Practical Nurses Association of Ontario (RPNAO)

Vida Vaitonis,
Ontario Health Providers Alliance

Joanne Young Evans, Executive Director
Registered Practical Nurses Association of Ontario

	Barbara Wahl, President Ontario Nurses' Association
	Micki Walters Colleges of Applied Arts & Technology (CAATs), Heads of Nursing
Support	Janine Hopkins, Senior Policy Analyst The Nursing Secretariat, Ministry of Health & Long-Term Care
RFP Coordinator	Judy Ponti-Sgargi, Eastern Region Ministry of Health & Long-Term Care

Appendix B: Site Visits

Summary of Site Visits

Twelve on-site visits were conducted as part of the Review and Audit of the 1999/2000 Nursing Enhancement Fund. The sites are listed in the table below:

Review and Audit Site Visit Locations	
Hospitals:	**City**
Humber River Regional Hospital	Toronto
Peterborough Regional Health Centre	Peterborough
Sudbury Regional Hospital	Sudbury
University Health Network	Toronto
St. Michael's Hospital	Toronto
London Health Sciences Centre	London
Riverdale Hospital	Toronto
LTC Facilities	
Castleview Wychwood Towers	Toronto
Versa Care Lodge	Ottawa
CCACs	
Peel	Brampton
Ottawa Carleton	Ottawa
Niagara	Niagara-on-the-Lake

Hospitals

Humber River Regional Hospital

President and CEO

Vice-President, Finance

Chief Nursing Officer

Staff R.N.

Director of Finance

Peterborough Regional Health Centre January 5, 2001

Chief Nursing Officer

Nursing Directors (2)

Nursing Committee Focus Group (including RN & RPN representation)

Sudbury Regional Hospital February 15, 2001

President & CEO

Vice President & Chief Nursing Officer

	Director of Finance
	Program Administrative Director
	Clinical Team Leaders (2)
	Coordinator of Trauma and Critical
University Health Network	Vice President Finance & CFO
	Finance Manager
	Staff RN, ONA Local Coordinator for all Sites, President of TTH and TWH sites
	Staff RN,ONA President PMH site
	Nurse Managers (2)
	Chief Nursing Officer
	Chief Executive Officer
	Site Nursing Coordinator
	Directors of Nursing (3)
St. Michael's Hospital	Chief Nursing Officer
	Chair, Nursing Council
	Finance Director
	Project Manager, Clinical and OP Services
	Financial Consultant
	Staff RNs (9)
	RN Resource Nurses (3)
	Clinical Leader Manager (CLM) (9)
	Clinical Nurse Specialists/Nurse Practitioners (4)
	Program Directors (3)
	ONA Bargaining Unit President
	RNAO representative
	Acting Director of Communications
London Health Sciences Centre	Chief Executive Officer
	Vice President, Patient Care and Chief Nursing Officer
	Program Tactical Managers (3)
	Program Coordinators (3)
	Director of Professional Practice, Nursing

	Business Manager
	Human Resources staff
	Staff RN (6)
	Staff RPN
Riverdale Hospital **January 18, 2001**	Chief Executive Officer
	Chief Nursing Officer
	Vice President, Corporate and Financial Services
	Program Director, Continuing Care
	Manager, Nursing Education
	Staff RN

LTC Facilities

Castleview Wychwood Towers	Administrator
	Director, Financial and Administrative Services
	Director of Nursing
	Head Nurse
	Staff R.N.
	Staff R.P.N.
Versa Care Lodge	Administrator
	Interim Administrator
	Resident/Family Services Manger
	Director of Resident Care
	Nurse Clinician

Community Care Access Centres

Peel CCAC **January 16, 2001**	Chief Executive Officer
	Director, Corporate Services
	Manager, Financial Services
	Director, Client Services
	Manager of Human Resources
	Manager, Client Services
	Intake staff (Registered Nurse)

Ottawa Carleton CCAC	Chief Executive Officer
	Director of Client Services
	Director of Corporate Services
	Case Manager (Registered Nurse)
Niagara CCAC	Chief Executive Officer
January 12, 2001	Director of Client Services
	Director of Corporate Services
	Director of Planning
	Case Manager (Registered Nurse)

Appendix C: Letter of Intent – Nursing Plan

Description

In order to receive full annualized funding, hospitals were required to sign and return (by April 20, 1999) a *Letter of Intent* to develop a nursing plan and obtain Ministry approval of their complete 1999/2000 Operating Plan. The following are excerpts from the Letter of Intent:

"...[hospital] Facility # [ ], agrees to develop a Nursing Plan which will support the government's Nursing Strategy. Our plan will address increased nursing hours per patient in our hospital and address our priority needs for increased nursing in areas such as critical care, emergency services and dialysis. In addition, we will identify other areas in our hospital that require enhanced nursing levels.

"Our plan will address the stabilization of nursing in our hospital and the issue of the casualization in our hospital through increased opportunities for permanent nursing positions. We will provide a breakdown of the proposed changes by professional designation (e.g. R.N., R.P.N., unregulated) and employment status (e.g. full-time, part-time, casual) in the formats provided.

"the Nursing Plan will be provided as part of the 1999/2000 Operating Plan due to the Ministry on June 28, 1999. We acknowledge that receipt of the fill nursing allocation is dependent upon approval of our 1999/2000 Operating Plan, including the Nursing Plan."

[signed by:

Chief Executive Officer

Chair, Board of Directors

Chief Nursing Officer / Senior Nurse Executive]

Appendix D: Payroll Survey

Review and Audit of the 1999/2000 Nursing Enhancement Fund

Please fax completed survey to:

Hay Health Care Consulting Group, (416) 868-0362

Please complete this survey based on **payroll information** for the complete fiscal years 1998/1999 and 1999/2000. The information is to include all nursing functional centres: nursing administration, nursing inpatient and ambulatory care (functional centres 712* and 713*) and all hours including hours purchased from agencies and overtime hours. Please note that only hours for RNs and RPNs are to be repotted; health care workers other than RNs and RPNs are excluded from this survey. Earned hours are defined in the MIS Guidelines as worked hours plus benefit hours plus purchased service hours.

1. Please provide the total earned hours for nursing staff by category as in the table below:

Table 1 – Nurse Staffing Hours

Staff Category	Total Earned Hours: 1998/1999	Total Earned Hours: 1999/2000
RN - Full Time		
RN - Part Time		
RN - Casual		
RPN - Full Time		
RPN - Part Time		
RPN - Casual		

2. Please provide the earned hours for agency nursing in the table below and indicate whether these hours have been included in Table 1 (above):

Table 2 – Nursing Hours Provided by Agency Staff

Staff Category	April 1, 1998 to March 31, 1999	April 1, 1999 to March 31, 2000
RN		
RPN		
Are these hours included in Table 1 (above)?	Yes ❑	No ❑

3. Please provide the over time worked hours for nursing staff by category as in the table below:

Table 3 – Overtime Worked Hours for Nursing Staff

Staff Category	April 1, 1998 to March 31, 1999	April 1, 1999 to March 31, 2000
RN		
RPN		
Are these hours included in Table 1 (above)?	Yes ❑	No ❑

4. Please provide the current nursing vacancies by category of nurse and by employment status. (Confirm that these are being recruited).

Table 4 – Current Nursing Vacancies

Staff Category	Vacancies as at March 31, 2000
RN - Full Time	
RN - Part Time	
RN - Casual	
RPN - Full Time	
RPN - Part Time	
RPN - Casual	

Appendix E: MIS Trial Balance Analysis

Documentation of MIS Calculations

Worked and Paid hours MIS data was collected for both UPP and UPP and M&O. In order to compare MIS data to nursing hour data reported in the hospital operating plans, only similar MIS data was assembled. This was done by using the MIS OHRS version 4.0 Reference Codes reported in the hospital operating plans in order to group the MIS data into comparable segments of nursing hours. The following table show the reference codes used by nursing hour type.

Table 1: 'Inpatient' Reference Codes

MIS OHRS VERSION 4.0 Reference Codes	
Primary Account(s)	Secondary Statistical Account(s)
71210*	403**
71210*	350*
71210*	350*
71210*	350*
71220*	403**
71220*	350*
71220*	350*
71220*	350*
71230*	403**
71230* + 71235	350*
71230* + 71235	350*
71230* + 71235	350*
71270*	403**
71270*	350*
71270*	350*
71270*	350*
71240* + 71242	403**
71240* + 71242	350*
71240* + 71242	350*
71240* + 71242	350*
71250*	403**
71250*	350*
71250*	350*
71250*	350*
71276*	403**
71276*	350*
71276*	350*
71276*	350*

Table 2: 'Long Term Care' Reference Codes

MIS OHRS VERSION 4.0 Reference Codes	
Primary Account(s)	Secondary Statistical Account(s)
71281	403*
71281	350*
71281	350*
71281	350*
71294, 7129520, 7129540	403*
71294, 7129520, 7129540	350*
71294, 7129520, 7129540	350*
71294, 7129520, 7129540	350*
7129560	403*
7129560	350*
7129560	350*
7129560	350*

Table 3: 'Ambulatory & Emergency' Reference Codes

MIS OHRS VERSION 4.0 Reference Codes	
Primary Account(s)	Secondary Statistical Account(s)
71310* + 71510* + 71515*	416* + 418* + 5*
71310* + 71510* + 71515*	350*
71310* + 71510* + 71515*	350*
71310* + 71510* + 71515*	350*
71340* + 71520*	416* + 418* + 5*
71340* + 71520*	350*
71340* + 71520*	350*
71340* + 71520*	350*
71350* + 71530* + 71535* + 71540* + 71550* + 71555* +	416* + 418* + 5*
71350* + 71530* + 71535* + 71540* + 71550* + 71555* +	350*
71350* + 71530* + 71535* + 71540* + 71550* + 71555* +	350*
71540* + 71550* + 71555* + 71558*	350*

Table 4: 'Miscellaneous' Reference Codes

MIS OHRS VERSION 4.0 Reference Codes	
Primary Account(s)	Secondary Statistical Account(s)
71260*, 71262*, 71265*	350*
71260*, 71262*, 71265*	350*
71260*, 71262*, 71265*	350*
7120520*	350*
7120520*	350*
7120520*	350*
7120510 + 71206 + 71305 + 71306 + 71505	310*, 350*, 390*
7120510 + 71206 + 71305 + 71306 + 71505	310*, 350*, 390*
7120510 + 71206 + 71305 + 71306 + 71505	310*, 350*, 390*
712, 713, 715	310*, 390*
712, 713, 715	310*, 390*
712, 713, 715	310*, 390*